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In The

# Supreme Court of the United States

MICHAEL GEDDES AND KARI GEDDES, INDIVIDUALLY AND AS PARENTS AND GUARDIANS OF ANDREW GEDDES, A MINOR CHILD,

*Petitioners,*

v.

UNITED STAFFING ALLIANCE EMPLOYEE MEDICAL PLAN; U.S.A. UNITED STAFFING ALLIANCE, L.L.C., A LIMITED LIABILITY COMPANY, AND EVEREST ADMINISTRATORS, INC.,

*Respondents.*

**On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit**

## PETITION FOR WRIT OF CERTIORARI

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## QUESTION PRESENTED

Did the United States Court of Appeals for the Tenth Circuit correctly rule that the decision to deny the Geddeses' claim for medical benefits was entitled to ERISA abuse of discretion review where it also ruled that the entity that made that decision was not a fiduciary, and is not even subject to suit under ERISA?

## LIST OF ALL PARTIES

All parties to the proceeding in the Tenth Circuit Court of Appeals appear in the caption of the case. There are no parents or subsidiaries whose disclosure is required under Rule 29.6.

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## STATEMENT OF BASIS FOR JURISDICTION

The United States Court of Appeals for the Tenth Circuit entered its judgment on November 15, 2006. Petitioners timely filed their Petition for Rehearing En Banc, which was denied on February 1, 2007. (App., *infra*, 68a). The Court has jurisdiction pursuant to 29 U.S.C. § 1254(1) (2000).

## STATUTES INVOLVED

*29 U.S.C. 1002(21)*:

For purposes of this subchapter:

* * *

(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent

(i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets,

(ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or

(iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.

(B) If any money or other property of an employee benefit plan is invested in securities issued by an investment company registered under the Investment Company Act of 1940 [15 U.S.C. 80a-1 et seq.], such investment shall not by itself cause such investment company or such investment company's investment adviser or principal underwriter to be deemed to be a fiduciary or a party in interest as those terms are defined in this subchapter, except insofar as such investment company or its investment adviser or principal underwriter acts in connection with an employee benefit plan covering employees of the investment company, the investment adviser, or its principal underwriter. Nothing contained in this subparagraph shall limit the duties imposed on such investment company, investment adviser, or principal underwriter by any other law.

*29 U.S.C. § 1105(c)*:

(c) Allocation of fiduciary responsibility; designated persons to carry out fiduciary responsibilities

(1) The instrument under which a plan is maintained may expressly provide for procedures

(A) for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries, and

(B) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan.

(2) If a plan expressly provides for a procedure described in paragraph (1), and pursuant to such procedure any fiduciary responsibility of a named fiduciary is allocated to any person, or a person is designated to carry out any such responsibility, then such named fiduciary shall not be liable for an act or omission of such person in carrying out such responsibility except to the extent that –

(A) the named fiduciary violated section 1104(a)(1) of this title –

(i) with respect to such allocation or designation,

(ii) with respect to the establishment or implementation of the procedure under paragraph (1), or

(iii) in continuing the allocation or designation; or

(B) the named fiduciary would otherwise be liable in accordance with subsection (a) of this section.

(3) For purposes of this subsection, the term "trustee responsibility" means any responsibility provided in the plan's trust instrument (if any) to manage or control the assets of the plan, other than a power under the trust instrument of a named fiduciary to appoint an investment manager in accordance with section 1102(c)(3) of this title.

*29 U.S.C. 1132(a)(1)(B)*:

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

## STATEMENT OF THE CASE
## FACTUAL BACKGROUND

Andrew Geddes, a Utah teenager, badly damaged his spinal cord after diving into shallow water at Lake Powell in the summer of 2002. (App., *infra*, 2a). An air ambulance transported Andrew from Lake Powell to St. Mary's Hospital in Grand Junction, Colorado, where physicians determined he had severely injured his neck and spinal column. (App., *infra*, 2a). He suffered paralysis in all of his limbs and was placed in intensive care. (App., *infra*, 2a).

On July 1, 2002, Andrew underwent surgery to repair his spine. (App., *infra*, 3a). Following the operation, Andrew remained in the intensive care unit with a halo device screwed to his skull to prevent his repaired spinal chord from slipping. (App., *infra*, 3a). He received nourishment intravenously until he left St. Mary's for Primary Children's Hospital in Salt Lake City, Utah, on July 15, 2002. (App., *infra*, 3a).

Due to his fragile condition, Andrew's physicians at St. Mary's recommended he be transferred to Primary Children's Hospital by helicopter. (App., *infra*, 3a). But his parents' health plan, United Staffing Alliance – Defendants here – denied coverage for this mode of transport. (App., *infra*, 3a). Andrew was taken the five hours from Grand Junction to Salt Lake City by ground ambulance, and once at Primary Children's, was admitted to the neuroscience ward. (App., *infra*, 3a).

For the next two months, Andrew received in-patient care at Primary Children's Hospital. (App., *infra*, 3a). He arrived still wearing the halo apparatus, catheterized, attached to an intravenous drip, and with splints on his arms and both legs. (App., *infra*, 3a). Andrew's primary treating physician at Primary Children's, Dr. Terese Such-Neibar, diagnosed Andrew with a "C-4 asia class C spinal" injury complicated by a urinary tract infection. (App., *infra*, 3a). She recommended two months of rehabilitation, bowel and bladder treatment, medication for infectious disease, and pain control. (App., *infra*, 3a). Hospital personnel also provided Andrew with respiratory and radiological treatment until his discharge on September 10, 2002. (App., *infra*, 3a).

Andrew was eligible for healthcare coverage under the United Staffing Alliance Employee Medical Plan (the "Plan"), in which he participated as a dependent through his father's employer. (App., *infra*, 3a-4a). The Plan is an employee welfare benefit plan as defined by the Employee Retirement Income Security Act of 1974, "ERISA," 29 U.S.C. §§ 1001-1461. (App., *infra*, 4a). The Plan's terms are defined in the Master Plan Description. (App., *infra*, 4a). The Plan names United Staffing as both fiduciary and administrator and provides that as the fiduciary, United

Staffing will engage an independent third party to review members' claims and administer all benefits. (App., *infra*, 4a). United Staffing retained Everest Administrators, Inc. as the third party claims administrator. (App., *infra*, 4a). Importantly, the Plan explicitly reserves to United Staffing the right to make all final decisions about benefits paid under its terms, as well as the authority to interpret disputed Plan provisions. (App., *infra*, 4a). The contract between United Staffing and Everest stated,

> The Contract Administrator [Everest] shall not be deemed a Plan "fiduciary" as defined in ERISA. [Everest's] services shall not include any power to make decisions regarding Plan policy, interpretations, practices or procedures, but shall be confined to ministerial functions such as those described by the U.S. Department of Labor in its Regulations Section 2509.75-8, D-2. . . . [Everest] shall have no final discretionary control over Plan management, including disposition of Plan assets and Plan administration. [Everest's] services hereunder shall be subject to review, modification, or reversal by the Plan Sponsor and/or Plan Administrator.

(App., *infra*, 30a-31a). The Plan ultimately covered less than half of the cost of Andrew's treatment at St. Mary's Hospital. (App., *infra*, 4a). The district court reversed this decision and ordered the Plan to pay for all of the St. Mary's treatment. (App., *infra*, 58a-59a). The Tenth Circuit affirmed this decision, and it is not at issue in this Petition for Certiorari. (App., *infra*, 21a).

United Staffing denied virtually all of the Geddeses' claims arising out of Andrew's stay at Primary Children's Hospital in Salt Lake City. The Plan contended that

Andrew's treatment there amounted to rehabilitation, for which the Plan imposed a $2,500 cap. (App., *infra*, 4a).

It was undisputed in the district court that Everest made all decisions regarding benefit claims. United Staffing did not participate at all in the Plan's adjudication of such claims. (App., *infra*, 38a-39a).

The district court reversed the Plan's decision as to the Primary Children's Hospital claims and ordered those claims covered. In so doing, it applied de novo review to the Plan's denial of the Geddeses' claim for benefits. The court held that because Everest was not a fiduciary and was not granted discretion under the Plan, there was not exercise of ERISA discretion to which it was obligated to defer. (App., *infra*, 52a).

The Tenth Circuit Court of Appeals reversed the district court's decision regarding the appropriate standard of review. It held that the decisions of a third-party claims administrator, made at the behest of a plan fiduciary, are exercises of ERISA discretion and entitled to discretionary review. Oddly, the Tenth Circuit also ruled that although Everest's decision were entitled to ERISA deference, Everest itself was a non-fiduciary and owed no duties to the Geddeses, and that, for this reason, the Geddeses had no recourse against it for benefits under ERISA.

The Geddeses petitioned for *en banc* rehearing of the standard of review issue. The court denied the petition.

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## REASONS FOR GRANTING THE PETITION.

### I. THE TENTH CIRCUIT'S DECISION CREATES A CONFLICT AMONG THE CIRCUITS REGARDING THE CORRECT STANDARD OF REVIEW FOR BENEFITS DETERMINATIONS RENDERED BY NON-FIDUCIARIES.

The Tenth Circuit held that the decisions of Everest, the Plan's claims administrator, were entitled to ERISA deference while holding at the same time that the claims administrator could not be sued under ERISA because it was a non-fiduciary. This extraordinary decision creates a conflict among the circuits regarding the appropriate standard review under ERISA for decisions made by non-fiduciaries. The Tenth Circuit explicitly recognized that its decision conflicts with the precedent of at least one other circuit.

> Although the Geddeses refer us to no cases adopting a contrary interpretation, we are aware of ***at least one circuit that disagrees with our conclusion***. In *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288 (11th Cir. 1990), the Eleventh Circuit held that in order to qualify for *Firestone* deference, an ERISA plan administrator that delegates its authority must do so only to other fiduciaries.

(emphasis added). The Tenth Circuit disagreed with the Eleventh Circuit and held that a discretionary authority may be delegated to non-fiduciaries.

In *Baker*, the plaintiff, Baker, claimed that he had been wrongfully denied long term disability benefits under an ERISA-governed employee benefit plan. *Baker*, 893 F.2d at 289. Connecticut General Life Insurance Company ("Connecticut General"), the "administrator" of the disability

plan and a *non-fiduciary*, was the party that made the ultimate decision to deny Baker's claim for benefits. *Id.* at 289-90. After finding that Connecticut General was not a fiduciary, the court applied this Court's decision in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989) to determine the correct standard of review for Connecticut General's decision to deny benefits.

The Eleventh Circuit began its analysis by quoting *Firestone*: "'a denial of benefits challenged under [29 U.S.C.] § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.'" *Baker*, 893 F.2d at 290-91 (quoting *Firestone*, 109 S. Ct. at 956) (alterations and italics in original). The Eleventh Circuit read this language to plainly state that,

> A court must exercise *de novo* review unless (1) the plan *fiduciary* has "discretionary authority to determine eligibility for benefits or to construe the terms of the plan"; or (2) the plan *administrator* has "discretionary authority to determine eligibility for benefits or to construe the terms of the plan."

*Id.* at 291 (italics in original).

The court next recognized that under ERISA, "an administrator with discretionary authority *is* a fiduciary" by definition. *Id.* (citing *Firestone*, 109 S. Ct. at 955) (emphasis in original). Presumably, the language in *Firestone* upon which the Eleventh Circuit relied in reaching this conclusion is as follows:

> Firestone concludes that an ERISA plan administrator, fiduciary, or trustee is empowered to exercise all his authority in a discretionary manner subject only to review for arbitrariness and capriciousness. But the provisions relied upon so heavily by Firestone do not characterize a fiduciary as one who exercises entirely discretionary authority or control. Rather, ***one is a fiduciary to the extent he exercises any discretionary authority or control.***

*Firestone*, 489 U.S. at 113 (emphasis added); *see also* 29 U.S.C. § 1105(c)(1)(B) ("A person is a fiduciary with respect to a plan to the extent (i) he exercises *any* discretionary authority or discretionary control respecting management or disposition of its assets, . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan."). Applying this logic, the Eleventh Circuit reasoned that the converse must also be true. Specifically, "[O]ne who is *not* a fiduciary is also not 'an administrator with discretionary authority.'" *Baker*, 893 F.2d at 291. The court then concluded that because Connecticut General was not a fiduciary, it did not exercise discretionary authority, and, for this reason, its decisions were not entitled to deferential review. *Id.*

Thus, the Eleventh Circuit essentially held that it is a logical impossibility under *Firestone* to conclude that a non-fiduciary administrator's decisions should be afforded abuse of discretion review, because a non-fiduciary, by definition, does not exercise discretion.

The instant case is factually indistinguishable from *Baker*. The Geddeses sued claiming they were wrongfully denied medical benefits under an employee benefit plan governed by ERISA. Everest, like Connecticut General,

made all determinations regarding the disposition of Plan benefits, even though the contract between Everest and United Staffing specifically stated that Everest was *not* a fiduciary and did *not* have discretion. Moreover, just as the court in *Baker* found that Connecticut General was not a fiduciary, the Tenth Circuit held that Everest was not a fiduciary and hence not subject to suit under ERISA.

Despite the factual similarity between the two cases, the Tenth Circuit held that Everest's decisions were entitled to *Firestone* deference. In reaching this holding, the court relied upon 29 U.S.C. § 1105(c)(1) (2006) of ERISA, which states,

> c) Allocation of fiduciary responsibility; designated persons to carry out fiduciary responsibilities
>
> (1) The instrument under which a plan is maintained may expressly provide for procedures
>
> (A) for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries, and
>
> (B) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan.

The court interpreted this language to mean that plan fiduciaries can delegate fiduciary functions and authority to non-fiduciaries, and that the decisions made by the non-fiduciaries are entitled to abuse of discretion review.[1] The

[1] The Tenth Circuit also engaged in a lengthy discussion of trust law. The thrust of its discussion was the notion that "while a fiduciary may not delegate the entire administration of his trust absent specific

(Continued on following page)

court held that this is so even though applicable Plan documents stated that Everest did not have discretionary authority to administer the plan or interpret its terms. The court held, "Decisions made by an independent, non-fiduciary third party at the behest of the fiduciary plan administrator are entitled to *Firestone* deference." (App., *infra*, 14a).

The Tenth Circuit's holding in this case is completely at odds with the Eleventh Circuit's holding in *Baker*. Under *Baker*, abuse of discretion review is triggered only when a delegation from a fiduciary to an independent third party includes a delegation of discretion – thereby making that third party himself a fiduciary to the extent he exercises that discretion. Under the Tenth Circuit's holding in this case, abuse of discretion review is triggered regardless of whether discretion is delegated to the independent third-party; all that matters is that the delegating fiduciary has discretionary authority.

The Tenth Circuit decision in the instant case also conflicts with the approach the Ninth Circuit Court of Appeals. In *Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279 (9th Cir. 1990), that court stated,

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authorizing language in the trust instrument, a fiduciary may delegate the performance of certain tasks." (quoting Restatement (Second) Trusts § 171 cmt. J). Relying upon this language from the Restatement, the court concluded that it was permissible for United Staffing to delegate certain tasks to Everest, a notion with which the Geddeses have never disagreed. Instead, the Geddeses contend that the relevant question is whether the tasks Everest performed involved an exercise of ERISA discretion.

> [W]here (1) the ERISA plan expressly gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan and (2) pursuant to ERISA . . . a named fiduciary ***properly designates another fiduciary, delegating its discretionary authority***, the 'arbitrary and capricious' standard of review . . . applies to the designated ERISA-fiduciary as well as to the named fiduciary.

*Id.* at 1283-84 (emphasis added).

The Tenth Circuit's decision creates a conflict among the circuits. For this reason, the Court should grant the Geddeses' Petition in order to resolve the conflict.

## II. THE TENTH CIRCUIT'S DECISION CONFLICTS WITH THE PLAIN LANGUAGE OF THE ERISA STATUTE AND THIS COURT'S HOLDING IN *FIRESTONE*.

The Tenth Circuit's conclusion that a non-fiduciary third-party claims administrator who has explicitly been denied discretion can exercise ERISA discretion sufficient to trigger arbitrary and capricious review conflicts with ERISA and this Court's *Firestone* decision. 29 U.S.C. § 1002(21) or ERISA provides a functional definition of "fiduciary." That provision, in relevant part, states,

> (A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent
>
> * * *
>
> (iii) he has any discretionary authority or discretionary responsibility in the administration of

> such plan. ***Such term includes any person designated under section 1105(c)(1)(B) of this title.***

(Emphasis added). Thus, one is a fiduciary under ERISA to the extent that he is designated by a named fiduciary "to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan." 29 U.S.C. § 1105(c)(1)(B).

The Tenth Circuit's holding directly contradicts the plain language of this statute. The crux of the court's holding is that Section 1105(c)(1)(B) permits and "endorses" a named fiduciary's delegation of authority to a *non*-fiduciary. (App., *infra*, 8a-9a). The statute supports no such thing. Instead, Section 1002(21) states that anyone delegated fiduciary responsibilities pursuant to Section 1105(c)(1)(B) is himself, *de facto*, a fiduciary. Thus, while it is true that United Staffing could have delegated authority to Everest under Section 1105(c)(1)(B), such a delegation would have made Everest a fiduciary, and the court specifically found that Everest is not a fiduciary.

Stated another way, under the statute, the Tenth Circuit could have found one of the following: (1) that Everest was delegated authority pursuant to Section 1105(c)(1)(B), and became a fiduciary because of that delegation pursuant to Section 1002(21); or (2) that Everest was a non-fiduciary and hence not delegated authority pursuant to Section 1105(c)(1)(B). Problematically, the Tenth Circuit instead found that Everest was delegated authority under Section 1105(c)(1)(B), but then found that Everest was *not* a fiduciary. This reading of ERISA requires one to completely ignore the plain language of Section 1002(21), which specifically states that the term "fiduciary" ***includes any person designated under section 1105(c)(1)(B) of this title***. The Tenth Circuit's

interpretation is, thus, impermissible and conflicts with the plain language of the ERISA statute.[2] *See Gustafson v. Alloyd Co., Inc.*, 513 U.S. 561, 115 S. Ct. 1061, 131 L. Ed. 2d 1 (1995) (statutes should not be read as a "series of unrelated and isolated provisions."); *Smith v. U.S.*, 508 U.S. 223, 233, 113 S. Ct. 2050, 124 L. Ed. 2d 138 (1993) ("Statutory construction . . . is a holistic endeavor." (Citation omitted)).

Moreover, both Section 1002(21) and *Firestone* state that one is a fiduciary to the extent he exercises discretionary authority. *See Firestone*, 489 U.S. at 113 ("[O]ne is a fiduciary to the extent he exercises any discretionary authority or control."). Thus, if one is a non-fiduciary, he does not exercise discretion. The Tenth Circuit's decision conflicts with Firestone and Section 1002(21) because it takes the position that a third-party claims administrator like Everest can exercise discretionary authority while still remaining a non-fiduciary – an impossibility under ERISA and *Firestone*.

The Tenth Circuit held that Everest was not a fiduciary. In light of this finding, the Tenth Circuit was likewise compelled to find that no delegation of fiduciary authority occurred pursuant to 29 U.S.C. § 1105(c)(1)(B), that

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[2] The Tenth Circuit's error appears to be fueled, at least in part, by its implicit failure to recognize that ERISA contemplates the existence of both named and unnamed fiduciaries. Although its does not explicitly say so, the court's decision appears to presume that one must either be a named fiduciary or a non-fiduciary. It is well-established, however, that "ERISA contemplates the existence of both named and unnamed fiduciaries." *Maez v. Mountain States Telephone & Telegraph, Inc.*, 54 F.3d 1488, 1498 (10th Cir. 1995); *see also Glanton ex rel. ALCOA Prescription Drug Plan v. AdvancePCS Inc.*, 465 F.3d 1123, 1124 (9th Cir. 2006) (stating that section [1002(21)] of ERISA makes no distinction between named and unnamed fiduciaries.).

Everest did not exercise discretion, and that its decisions were subject to *de novo* review. Because the Tenth Circuit's decision conflicts with both Firestone and ERISA itself, the Court should grant this Petition.

## III. THE TERMS "FIDUCIARY" AND "NON-FIDUCIARY" ARE NOT MERE LABELS; INSTEAD, THE DISTINCTION BETWEEN THE TWO GOES TO THE VERY HEART OF ERISA.

The Tenth Circuit's conclusion that a non-fiduciary, not subject to suit under ERISA, can exercise *Firestone* discretion is of no small import and moves beyond mere questions of semantics and labels (i.e. fiduciary vs. non-fiduciary). The question presented by this Petition goes to the very heart of ERISA's purposes. One of ERISA's stated purposes is "protecting . . . the interests of participants in employee benefit plans and their beneficiaries, by . . . establishing standards of conduct, responsibility, and obligation for *fiduciaries* of employee benefit plans. . . ." 29 U.S.C. § 1001(b). The statute's use of the term "fiduciary" is significant because, as this Court has recognized, ERISA is rooted in trust law. In fact, the Court's decision in *Firestone* was founded upon trust law principles. *See Firestone*, 489 U.S. at 110-15. These principles recognize that a fiduciary owes duties to the beneficiaries of the trust. *See* Restatement (Second) Trusts § 169-185 (noting that a trustee is a fiduciary and setting forth the various duties of the trustee as fiduciary). In the instant case, the Tenth Circuit held that because Everest was a non-fiduciary, it did not owe any duties to the trust's beneficiaries. (App. *infra*, 23a).

Because a fiduciary's decisions are governed by the duties he owes to the beneficiary's of the plan, it is logical

that a Court should be required to defer to his discretion. Certainly, this notion was the driving force behind the Court's decision in *Firestone* – that the courts should defer to the duty-laden decision-making of an ERISA fiduciary. This construction of ERISA also makes sense in light of the Court's statement that one is a fiduciary to the extent he exercises discretion, because an exercise of discretion should trigger the fiduciary duties that temper the exercise of that discretion. In this regard, the exercise of discretion under ERISA is very much a give and take. When one exercises discretion, he becomes a fiduciary and must take upon himself fiduciary duties as to the matters with the scope of his discretion. In return, the courts will only interfere with his decision-making if his decisions are arbitrary and capricious.

The Tenth Circuit's decision undermines ERISA, and it ignores these bedrock principles of trust law. Its reasoning renders the term "fiduciary" a hollow term, because it gives deference to the decisions of non-fiduciaries, who owe no duties to plan beneficiaries and thus have not earned that deference.

The results of such an approach are startling and antithetical to the very purposes of ERISA. The Tenth Circuit has created a scheme under which a non-fiduciary, who cannot even be hailed into court to answer for its decisions, is nonetheless given deference in its decision-making. The instant case provides a poignant example of the results of such non-fiduciary decision-making. Judge Holloway, who dissented from the decision, effectively summarized Everest's "administration" of the Geddeses' claims,

> This is, so far as I can determine, the best description available of how the claims for care at Primary Children's Hospital were handled. The hospital chose to use the numerical code for rehabilitative services rather than the code for services connected with hospitalization for most of the services provided. Rehabilitative services were limited under the plan to $2,500.00. Everest read the codes used by the hospital and mechanically applied the limitation stated in the plan. This is the "exercise of discretion" to which, the majority holds, deference is required.

(App., *infra*, 33a). Decisions like the one rendered by Everest in this case, which give slight, if any, consideration to beneficiaries' claims do not serve ERISA's stated purposes of "protecting the interests of participants in employee benefit plans and their beneficiaries, by . . . establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans." Under the Tenth Circuit's holding, beneficiaries like the Geddeses', whose claims were not reviewed by anyone who owes fiduciary duties, can only challenge such decisions if they are arbitrary and capricious. Because the conflict that now exists between the circuits regarding the proper standard of review for ERISA benefits decision made by non-fiduciaries is of great importance, this Court should grant the Geddeses' Petition for Certiorari to resolve the conflict.

As a final note, the conflict among the Tenth, Eleventh and Ninth Circuits creates a situation where litigants under the same benefits plan will be litigating under very different standards of review and where employers with multi-state benefits plans will be subject to inconsistent standards. The situation created by the Tenth Circuit's

decision thus defeats one of ERISA's primary objectives – "to provide a uniform regulatory regime." *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004); *see also Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002) (recognizing "ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards").

Because the Tenth Circuit decision and the conflict it creates are of considerable importance, this Court should grant the Geddeses' Petition for Certiorari.

## CONCLUSION

For the foregoing reasons, Petitioners respectfully request that this Court grant the petition for writ of certiorari.

Respectfully submitted, May 2, 2007.

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## APPENDIX A

469 F.3d 919

**UNITED STATES COURT OF APPEALS**
**TENTH CIRCUIT**

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MICHAEL GEDDES and KARI GEDDES, individually and as parents and guardians of ANDREW GEDDES, a minor child,

Plaintiffs-Appellees,

v.

UNITED STAFFING ALLIANCE EMPLOYEE MEDICAL PLAN; U.S.A. UNITED STAFFING ALLIANCE, L.L.C., a limited liability company, and EVEREST ADMINISTRATORS, INC., a Utah corporation,

Defendants-Appellants.

No. 05-4142

(Filed Nov. 15, 2006)

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**APPEAL FROM THE UNITED STATES DISTRICT COURT OR THE DISTRICT OF UTAH**
**(D.C. NO. 2:03-CV-440-PGC)**

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D. David Lambert, (Leslie W. Slaugh, with him on the brief) Howard, Lewis & Petersen, L.L.C., Provo, Utah, for Defendant-Appellant Everest Administrators, Inc.

Lawrence D. Buhler, Salt Lake City Utah, for Defendant-Appellant United Staffing Alliance, L.L.C.

Jeffrey J. Droubay (Michael L. Larson with him on the briefs) Parsons Behle & Latimer, Salt Lake City, Utah, for Plaintiffs-Appellees.

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Before **KELLY**, **HOLLOWAY**, and **McCONNELL**, Circuit Judges.

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**McCONNELL**, Circuit Judge.

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Since the Supreme Court's decision in *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101 (1989), federal courts have reviewed an ERISA health plan's denial of benefits for arbitrariness and capriciousness, so long as the plan explicitly grants discretionary authority to an administrator or other fiduciary to render benefit decisions. Now we are called upon to decide whether a fiduciary's decision to delegate part of its *Firestone* authority to an independent claims administrator triggers *de novo* review. We hold that it does not.

## I. Background

Andrew Geddes, a Utah teenager, badly damaged his spinal cord on a church-sponsored excursion to Lake Powell in the summer of 2002. On June 27, he dove into shallow water from the lake's edge and resurfaced unable to move his arms or legs. An air ambulance transported Andrew from Lake Powell to St. Mary's Hospital in Grand Junction, Colorado, where physicians determined he had severely injured his neck and spinal column. He was placed in intensive care.

On July 1, 2002, Andrew underwent surgery to repair his spine. Following the operation, Andrew remained in the intensive care unit with a halo device screwed to his skull to prevent his repaired spinal chord from slipping. He received nourishment intravenously until he left St. Mary's for Primary Children's Hospital in Salt Lake City, Utah, on July 15, 2002.

Due to his fragile condition, Andrew's physicians at St. Mary's recommended he be transferred to Primary Children's Hospital by helicopter. But his parents' health plan, United Staffing Alliance – Defendants here – denied coverage for this mode of transport. Andrew was taken the five hours from Grand Junction to Salt Lake City by ground ambulance, and once at Primary Children's, was admitted to the neuroscience ward.

For the next two months, Andrew received in-patient care at Primary Children's Hospital. He arrived still wearing the halo apparatus, catheterized, attached to an intravenous drip, and with splints on his arms and both legs. Andrew's primary treating physician at Primary Children's, Dr. Terese Such-Neibar, diagnosed Andrew with a "C-4 asia class C spinal" injury complicated by a urinary tract infection. She recommended two months of rehabilitation, bowel and bladder treatment, medication for infectious disease, and pain control – a regimen she stated was medically necessary and typical for patients in Andrew's condition. Hospital personnel also provided Andrew with respiratory and radiological treatment until his discharge on September 10, 2002.

The Geddeses depended for healthcare coverage on the United Staffing Alliance Employee Medical Plan, in which they participated as a family through Michael

Geddes' employer, United Staffing Alliance. The United Staffing Plan (the "Plan") is an employee welfare benefit plan as defined by the Employee Retirement Income Security Act of 1974, "ERISA," 29 U.S.C. §§ 1001-1461. The Plan's terms are defined in the Master Plan Description. All parties agree the Plan covered Andrew as a dependent at the time of his accident and subsequent treatment. The Plan names Defendant United Staffing as both fiduciary and administrator and provides that as the fiduciary, United Staffing will engage an independent third party to review members' claims and administer all benefits. That third party is Everest Administrators, Inc., also a defendant here. Through Everest, United Staffing contracted with a network of medical care providers to offer services to plan participants at discounted contract prices. The Plan also covers care given by out-of-network providers at the "usual and customary rate as determined by the Plan." Appellees' App. at 263. Importantly, the Plan explicitly reserves to United Staffing the right to make all final decisions about benefits paid under its terms, as well as the authority to interpret disputed Plan provisions.

At Everest Administrators' direction, United Staffing ultimately covered only $40,921 of Andrew's $185,892 in medical bills. United paid less than half of the cost of Andrew's treatment at St. Mary's Hospital on the ground that the hospital's charges exceeded the "usual and customary" rate covered by the Plan. United denied almost all of Andrew's claims arising from his stay at Primary Children's Hospital in Salt Lake City as well, contending Andrew's treatment there amounted to rehabilitation, for which the Plan imposed a $2,500 cap. In a series of letters and phone calls exchanged with Everest and Intracorp, another claims review agency employed by United Staffing,

Andrew's parents disputed both United's interpretation of "usual and customary" and its characterization of their son's treatment as "rehabilitative." United Staffing insists the Plan gives it wide discretion as Plan administrator and fiduciary to interpret the document's terms. And while Everest professed in a letter to the Geddeses' attorney to "completely agree that the rehabilitation care was medically necessary," it stood by its denial of benefits based on the terms of the Plan. The Geddeses filed suit in federal district court, asserting that United Staffing's denial of benefits was improper under ERISA § 502(a)(1)(B) and (a)(3). They also alleged a breach of fiduciary duty in violation of ERISA §§ 404(a) and 502(a)(3), and a violation of § 502(c)(1)(B) due to the Defendants' failure to provide requested Plan documents. Shortly thereafter, the parties filed cross motions for summary judgment.

The district court granted summary judgment in favor of the Geddeses on their first cause of action. The court entered judgment for United Staffing and Everest Administrators on claims two and three. United Staffing and Everest Administrators appeal from the district court's judgment in favor of the Geddeses. They contend the district court applied the incorrect standard of review, relied on extrinsic evidence beyond the administrative record, misinterpreted Plan provisions, and failed to consider United Staffing's pre-certification argument. Everest additionally claims that the district court's money judgment against it was clear legal error.

## II. Discussion

### A. Standard of Review for Benefit Determinations

The first and most significant issue we must decide is the standard to apply in reviewing United Staffing's denial of health benefits. This question colors all the rest. The district court concluded it had authority to review United's determinations *de novo,* rather than for arbitrariness and capriciousness. We disagree.

ERISA allows plaintiffs to sue in federal court to "recover benefits due . . . under the [healthcare] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). But the ERISA statute does not specify the judicial standard of review. The Supreme Court closed the lacuna in 1989, holding in *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101 (1989), that a denial of benefits challenged under § 1132(a)(1)(B) "is to be reviewed under a *de novo* standard, unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. If the plan does explicitly confer discretionary authority on an administrator with so-called *Firestone* language, courts must review benefit determinations under an "arbitrary and capricious" standard. *Chambers v. Family Health Plan,* 100 F.3d 818, 825 (10th Cir. 1996).

The United Plan contains *Firestone* language. The Master Plan Description provides: "The Company is the *named fiduciary* and is the *plan administrator* of the Plan. . . . [T]he Company makes all final decisions about benefits paid from the Plan." Appellees' App. at 250 (emphasis in original). Despite this provision, the district

court found that by delegating claims administration to Everest, United Staffing failed to exercise its administrative discretion and thereby forfeited its right to deferential review. The court relied for this conclusion on our decision in *Gilbertson v. Allied Signal Inc.*, 328 F.3d 625 (10th Cir. 2003), in which we held that a plan administrator must actually exercise the discretion the *Firestone* language confers in order to enjoy deferential review of its decisions. *Id.* at 631-32. In *Gilbertson,* the plan administrator failed to render a decision on a disability claim prior to the deadline, and the claim was accordingly "deemed denied" pursuant to ERISA regulations. *Id.* at 631. This Court held that "when substantial violations of ERISA deadlines result in the claim's being automatically denied on review, the district court must review the denial *de novo,* even if the plan administrator has discretionary authority to decide claims." *Id.* We reasoned that "[d]eference to the administrator's expertise is inapplicable where the administrator has failed to apply his expertise to a particular decision." *Id.* at 632. "[A] 'deemed denied' decision is by operation of law rather than the exercise of discretion." *Id.* at 631.

The district court below held that United Staffing's delegation of authority to an independent claims agency similarly constitutes a failure to exercise administrative discretion, triggering *de novo* review. Like many managed-care providers, United devolves the administrative task of reviewing beneficiary claims to an independent, non-fiduciary third party. The United Plan explicitly anticipates this delegation: "The Company will engage an independent *claims administrator* to administer the Plan, however, the Company makes all final decisions about

benefits paid from the Plan." Appellees' App. at 250 (emphasis in original).

The district court interpreted the ERISA statute to preclude judicial deference if fiduciaries pursue this sort of delegation. On the court's logic, the party to which a plan fiduciary or administrator delegates the responsibility to review claims must also be a fiduciary. If the administrator delegates responsibility to a non-fiduciary, the court reasoned, the plan effectively has no fiduciary exercising the sort of discretion that qualifies for *Firestone* deference. Therefore, United Staffing may not both claim judicial deference and delegate responsibility for claims administration to Everest, because Everest is an independent third party – that is, not itself a fiduciary under the Plan.[1] That Everest, on behalf of United Staffing, handled every claim submitted by the Geddeses led the district court to conclude that United Staffing effectively did nothing, totally failing for purposes of the ERISA statute and *Gilbertson* to exercise its discretion and thereby forfeiting its claim to deferential review.

We cannot agree with this logic, which we suspect was at least partly informed by the district court's misleadingly truncated reading of a provision of the ERISA statute. The district court quoted the statute to say: "The instrument under which a plan is maintained may expressly provide

[1] The district court found that Everest Administrators, Inc., was an independent, third-party non-fiduciary. Appellees' App. at 800. No party to this action argues otherwise, and we see no reason to revisit that conclusion. If Everest did qualify as an ERISA fiduciary under 29 U.S.C. § 1002(16)(A), 21(A), our conclusion that its benefits decisions on behalf of United Staffing are entitled to deferential review would follow all the more readily.

for procedures . . . (B) for named fiduciaries to carry out fiduciary responsibilities . . . under the plan." Appellees' App. at 801. From this, the court drew the negative inference that the Plan may not provide for non-fiduciaries to carry out fiduciary responsibilities – at least not without forfeiting judicial deference to the decisions made by the non-fiduciary. But the district court omitted a critical phrase from the statute, which actually reads: "The instrument under which a plan is maintained may expressly provide for procedures . . . (B) for named fiduciaries *to designate persons other than named fiduciaries* to carry out fiduciary responsibilities . . . under the plan." 29 U.S.C. § 1105(c)(1) (emphasis added). The plain language of the statute thus endorses the delegation to non-fiduciary third parties the district court found suspect.

Nor is the district court's interpretation a valid extension of either *Firestone* or this Court's decision in *Gilbertson*. To qualify their decisions for deferential review, *Firestone* requires only that ERISA health plan administrators and fiduciaries reserve discretionary authority to themselves in the plan document. 489 U.S. at 115. The Supreme Court arrived at this rule by relying on the principles of trust law. *Id.* at 111 ("In determining the appropriate standard of review for actions under § 1132(a)(1)(B), we are guided by principles of trust law."). Professor John Langbein has explained that "ERISA is, in its most important dimension, federal trust law. Substantively, the statute . . . absorbs the core fiduciary duties of loyalty and prudence from trust law and extends them to govern all aspects of plan administration." John L. Langbein, *What Erisa Means by "Equitable": The Supreme Court's Trail of Error in* Russell, Mertens, *and* Great-West, 103 Colum. L. Rev. 1317, 1319 (2003). Trust doctrine

teaches that if a trustee has been endowed by the trust instrument with discretionary authority, courts will not interfere with the trustee's decisionmaking unless he acts dishonestly or fails in his judgment. Restatement (Second) of Trusts § 187 cmt. e (1959). Following this instruction, the *Firestone* Court declined to limit how an ERISA plan administrator, vouchsafed discretion under the plan document, may exercise its discretionary authority. *See* 489 U.S. at 111. Specifically, *Firestone* does not limit the parties to whom a fiduciary may delegate its authority, beyond those limits implicit in the principles of trust law. Consequently, we turn to trust law itself for further guidance.

Long-accepted trust doctrine holds that while a fiduciary may not delegate the entire administration of his trust absent specific authorizing language in the trust instrument, a fiduciary may delegate the performance of certain tasks "which it is unreasonable to require him personally to perform." Restatement (Second) of Trusts § 171 cmt. d (1959). *See, e.g., Wachovia Bank and Trust Co. v. Morgan,* 182 S.E.2d 356, 363 (N.C. 1971). Trust law regards this discretion to delegate as inherent in the fiduciary-trustee. The fiduciary's inherent discretion is confirmed and extended when the authority to delegate is explicitly mentioned in the trust instrument. "By the terms of the trust a trustee may be permitted to delegate to agents or to co-trustees or to other persons the administration of the trust or the performance of acts which could not otherwise be properly delegated." Restatement (Second) of Trusts § 171 cmt. j; *see Central States v. Central Transport, Inc.,* 472 U.S. 559, 568-69, 570-71 (1985).

Importantly for the disposition of the issue before us, trust law does not require a fiduciary to delegate his

authority only to other fiduciaries. Rather, the trustee is at liberty to delegate administrative tasks to "agents" or "other persons" as is necessary to carry out the purposes of the trust. Restatement (Second) of Trusts § 171 cmt. j; *see also id.* § 186 cmt. d; *In re Butler's Trusts,* 26 N.W.2d 204, 211 (Minn. 1947); *Hagedorn v. Arens,* 150 A. 4, 8 (N.J. Ch. 1930). A fiduciary's decision to delegate does not violate his responsibility to the trust beneficiary insofar as the fiduciary himself remains personally liable for any decisions taken on his behalf. In sum, the fiduciary is responsible for actions performed in his name. Restatement (Second) of Trusts § 225 (1959). The same is true in the ERISA context.

Once a health plan administrator, the ERISA counterpart to trust law's fiduciary-trustee, has been delegated discretionary authority under the terms of the ERISA plan, nothing prevents that administrator from then delegating portions of its discretionary authority to non-fiduciary third parties, as any similarly-situated trustee may do. This is especially true when such delegation is explicitly authorized by the plan document. The plan administrator remains liable, however, for decisions rendered by its agents, just as a trustee remains ultimately responsible for the actions of his delegates. In the instant case, the Plan specifically empowered its fiduciary, United Staffing, to employ an independent third party to review benefit claims, even while reserving to United Staffing final authority over all benefit determinations. United Staffing's decision to delegate limited authority to Everest Administrators according to the terms of the controlling Plan instrument accords with *Firestone* and with the background principles of trust law. It does not

constitute a failure of fiduciary judgment sufficient to warrant *de novo* review.

The district court justified its contrary conclusion by citing to our decision in *Gilbertson,* but its reliance on that case is misplaced for two reasons. First, *Gilbertson's* core holding finds no application here. *Gilbertson* stands for the proposition that ERISA administrators are not entitled to deference for "deemed denied" decisions made "by operation of law rather than the exercise of discretion." 328 F.3d at 631. But Everest and United did not simply deem the Geddeses' claims "denied" without further review, as the defendant-administrator did in *Gilbertson. Id.* Instead, Everest made a benefits determination according to the procedures of the Plan, which United, as the Plan fiduciary, then accepted. Thus, unlike in *Gilbertson,* discretion was exercised by some combination of the fiduciary and its agent.

*Gilbertson* in no way implies, as the district court inferred, that plan fiduciaries qualify for *Firestone* deference only if they delegate their authority to other named fiduciaries. In fact, we approved in *Gilbertson* a plan administrator's delegation of claims review authority to an independent, third-party claims agency as an appropriate exercise of fiduciary discretion. 328 F.3d at 630. The facts are closely analogous to the situation here. The health plan administrator in *Gilbertson,* AlliedSignal, named a third party claims administrator, Life Insurance Company of North America, to administer its plan and determine eligibility benefits. *Id.* at 628. We found no fault with this procedure: "Allied Signal's plan expressly vests discretionary authority to determine benefits eligibility in the Plan Administrator [], who has delegated its discretion to LINA. . . . Therefore, because the Plan, albeit indirectly,

grants discretionary authority to LINA, LINA's decisions on benefit claims should generally be reviewed under the arbitrary and capricious standard." *Id.* at 630. We follow that analysis in the present case.

Although the Geddeses refer us to no cases adopting a contrary interpretation, we are aware of at least one circuit that disagrees with our conclusion. In *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288 (11th Cir. 1990), the Eleventh Circuit held that in order to qualify for *Firestone* deference, an ERISA plan administrator that delegates its authority must do so only to other fiduciaries. *Id.* at 291. The Eleventh Circuit's logic parallels the district court's in our case. "[A]ny entity or person found not to be an ERISA 'fiduciary' cannot be an 'administrator with discretionary authority' subject to the arbitrary and capricious standard." *Id.*[2] While we agree that an ERISA plan administrator must be a fiduciary, 29 U.S.C. § 1002(16)(A), 21(A), there is nothing in the language of the ERISA statute, the logic of *Firestone,* or the background principles of trust law that requires fiduciaries, when delegating authority, to delegate only to other

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[2] The Ninth Circuit's position regarding the power of named fiduciaries to delegate their authority is ambiguous. In *Madden v. ITT Long Term Disability Plan for Salaried Employees,* 914 F.2d 1279 (9th Cir. 1990), the Ninth Circuit held that "where (1) the ERISA plan expressly gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan and (2) pursuant to ERISA . . . a named fiduciary properly designates another fiduciary, delegating its discretionary authority, the 'arbitrary and capricious' standard of review . . . applies to the designated ERISA-fiduciary as well as to the named fiduciary." *Id.* at 1283-84 (internal citations omitted). This might be read to require that fiduciaries delegate their authority only to other fiduciaries in order to qualify for *Firestone* deference, but such an interpretation is not necessary and would, in any event, be dictum.

fiduciaries. Indeed, we would go so far as to say the plain language of the ERISA statute and the venerable body of trust law say just the opposite. Decisions made by an independent, non-fiduciary third party at the behest of the fiduciary plan administrator are entitled to *Firestone* deference because the third parties act only as agents of the fiduciary. For purposes of liability, decisions made by third parties are decisions made by the fiduciary. If a plan administrator has been allotted discretionary authority in the plan document, the decisions of both it and its agents are entitled to judicial deference.[3]

It remains now to apply this standard to the disputed claims denials in this case.

## B. The Primary Children's Claims

United Staffing declined to cover the majority of the Geddeses' medical costs from both Primary Children's Hospital in Salt Lake City and St. Mary's Hospital in Grand Junction, but for different reasons. With regard to the denial of coverage for Andrew Geddes's treatment at Primary Children's, United concluded that the care provided there was almost entirely rehabilitative in nature. As part of its evaluation of that rationale for denying benefits, the district court supplemented the administrative record with the affidavit of Dr. Teresa Such-Neibar and with evidence from deposition testimony. Appellees'

[3] Contrary to the dissent, it is immaterial for present purposes whether Everest's responsibilities are labeled "ministerial" or "discretionary." Either way, all decisions were made by United Staffing or by its agent-unlike *Gilbertson*, where the decision was made by operation of law, due to the failure of the fiduciary or its agent to make the relevant decision before the deadline.

App. at 795, 805, 806, 814. But a reviewing court is permitted to consider extrinsic evidence only on *de novo* review of a benefit claim. *Hall v. Unum Life Ins. Co. of Am.*, 300 F.3d 1197, 1202 (10th Cir. 2002) (holding courts may "supplement [the administrative] record when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision"). The district court's review should not have been *de novo*. Consequently, we direct the district court on remand to consider only evidence from the closed administrative record. In so doing, we imply no opinion as to the outcome the district court should reach under the arbitrary and capricious standard.

United Staffing also appeals from the district court's rejection of its claim that because the Geddeses failed to pre-certify Andrew's in-patient care at Primary Children's, United's denial of benefits was justified. The district court refused to consider this argument on summary judgment, finding United had failed to raise the claim at the proper time. Our case law forbids the district court from relying on new arguments or materials to decide a summary judgment motion unless the opposing party is provided an opportunity to respond. *Beaird v. Seagate Tech., Inc.*, 145 F.3d 1159, 1165 (10th Cir. 1998). Whether to allow supplemental briefing on a newly-raised issue is a "supervision of litigation" question we review for abuse of discretion. *See Pippin v. Burlington Res. Oil & Gas*, 440 F.3d 1186, 1192 (10th Cir. 2006); *Beaird*, 145 F.3d at 1164-65. We affirm the district court.

United Staffing contends it raised the pre-certification argument in its briefs before the district court, in its initial answer to Plaintiff Geddeses' complaint, and in its memorandum of opposition to the Geddeses' summary judgment

motion. Upon review of the record, we find no mention of the pre-certification argument in any of these places. United raised the issue at oral argument before the district court on December 8, 2004, and again in supplemental briefing to the court on February 11, 2005. Contrary to United's assertions, however, its initial answer to the Geddeses' complaint mentions nothing about pre-certification, but claims only that the Plan's denial of benefits was not arbitrary and capricious. Appellants' App. at 28-29. Similarly, United's memorandum in opposition to the Geddeses' motion for summary judgment quotes portions of correspondence between the Geddeses and Defendant Everest, including internal notations made by Everest that identify pre-certification as a problem. But United did not make an affirmative pre-certification argument at this stage either. Instead, the quotations are adduced in support of United's claim that it engaged in "meaningful dialogue" with the Geddeses. In effect, United seeks to bootstrap the pre-certification argument into the broader issue of its discretion as administrator under the Plan, though it failed to argue the pre-certification issue explicitly. The court did not abuse its discretion by refusing to consider the new issue at the late juncture when it was raised. *Beaird,* 145 F.3d at 1164-65.

In sum, we reverse the district court's judgment as to the Primary Children's claims and remand for reconsideration on the administrative record, according to an "arbitrary and capricious" standard of review. We affirm the district court's refusal to consider United's belated pre-certification claims.

### C. The St. Mary's Claims

United Staffing refused to pay more than $37,363.33 of the Geddeses' $86,460.70 in bills from St. Mary's Hospital in Grand Junction, on the ground that the hospital's charges exceeded the "usual and customary" fee United Staffing agreed to cover in the Plan document. Appellees' App. at 796. Applying a *de novo* standard of review, the district court held that this was an erroneous interpretation of the Plan. According to the district court, it would be unreasonable to interpret the "usual and customary" fee charged by an out-of-network provider to be equivalent to the fees charged by in-network providers, with whom the Plan negotiates discounted rates. As discussed above, the district court's use of a *de novo* standard of review was incorrect. But in analyzing this portion of the Geddeses' claim, the district court repeatedly invoked the language of arbitrary and capricious review, and relied in its opinion on an Eleventh Circuit holding reached under the arbitrary and capricious standard. We therefore interpret the district court as holding that United's interpretation of "usual and customary" is unreasonable under either standard of review, and affirm on that ground.

St. Mary's was a so-called "out-of-network" provider. The Plan authorizes payment to out-of-network providers only up to an allowed amount, which the Plan defines as "the usual and customary amount determined by the Plan." Appellees' App. at 263. What counts as "usual and customary," however, is not specified in the Plan document. The disputed provision states in full:

> **Allowable expenses.** For services provided by a participating provider. The contracted amount of payment to which the provider has agreed. For services provided by a non-participating provider,

> the usual and customary amount as determined by the Plan.

*Id.* Everest Administrators, as United's agent, defined "usual and customary" to mean "what the plan pays on average for in-network services." Appellants' App. at 166; *see also* Appellees' App. at 297-98. The Geddeses, by contrast, argue the provision reasonably means the market rate prevailing in a given geographic region.

Under the arbitrary and capricious standard, our inquiry is limited to determining whether the plan administrator's interpretation of the ambiguous language was "reasonable and made in good faith." *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1003 (quoting *Hickman v. GEM Ins. Co.*, 299 F.3d 1208, 1213 (10th Cir. 2002)). We will not substitute our own judgment for that of the plan administrator unless the administrator's actions are without any reasonable basis. *Woolsey v. Marion Lab.*, 934 F.2d 1452, 1460 (10th Cir. 1991); Restatement (Second) Trusts § 187 cmt. e. We ask four questions derived from the principles of trust law: (1) Is the interpretation the result of a reasoned and principled process? (2) Is it consistent with any prior interpretations by the plan administrator? (3) Is it reasonable in light of any external standards? And (4) is it consistent with the purposes of the plan? *Fought*, 379 F.3d at 1003; Restatement (Second) Trusts § 187 cmt. d (1959). We answer these queries based on the administrative record. *Hall*, 300 F.3d at 1201.

In the case at bar, the parties do not address whether United's interpretation was the result of a principled process or consistent with prior interpretations, and neither shall we. The Geddeses do maintain, however, that United's interpretation of "usual and customary" is unreasonable

and unfair, implicating the third and fourth inquiries above. Under factor three, we consider "the existence or non-existence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee's conduct can be judged." Restatement (Second) Trusts § 187 cmt. d. If there is such a standard, trust law generally holds the trustee guilty of an abuse of discretion if he contravenes it. *In re Curtis' Trust Estate,* 33 N.W.2d 193, 198 (Wis. 1948) (holding that while the trust instrument did not affirmatively require trustees to pay the beneficiary's taxes, such payment was reasonable and necessary to effect the purposes of the trust). In the present case, industry custom provides a reasonable external standard by which to evaluate United's interpretation of the ambiguous phrase, "usual and customary." When calculating payments to non-network providers, healthcare administrators typically rely on rate schedules assembled from a survey of average treatment charges in a given geographic region. *Hickman,* 299 F.3d at 1210; *Schwartz v. Oxford Health Plans, Inc.,* 175 F. Supp 2d 581, 589 (S.D.N.Y. 2001). Yet neither United nor Everest made any such surveys, and United did not include rate tables or benefit schedules in the Plan. Instead, United and Everest simply declared the "usual and customary" rate for out-of-network providers to be the same as the average for in-network providers. The district court found, and we agree, that interpreting a "customary" charge in the medical market as synonymous with the discounted rate negotiated by a health plan with its preferred providers is a significant deviation from industry custom.

What's more, that deviation frustrates the purposes of the Plan. According to the Plan document, United Staffing established its medical alliance "to make health care

benefits available to . . . qualifying employees and their eligible dependents." Appellees' App. at 250. But United's interpretation of "usual and customary" effectively denies plan members medical coverage if they, like the Geddeses, are forced to use an out-of-network provider. Nothing in the Plan document alerts beneficiaries to this significant limitation on their medical coverage. In fact, by juxtaposing the "contracted amount" for in-network providers with the "usual and customary" charge levied by out-of-network physicians – and by promising to cover both – the text of the Plan directly implies the two rates are distinct, and that out-of-network expenses will be covered at the prevailing market rate. *See* Appellees' App. at 263.

In analyzing a similar provision in another ERISA health plan, the Eleventh Circuit noted that the "usual and customary fee is the reasonable fee," the fee a prudent person would expect to pay based on the prevailing market rate. *HCA Health Serv. of Ga., Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 997 (11th Cir. 2001). A prudent person "would not even consider the discounted fee because it only arises out of a specified contractual relationship." *Id.* That is, the in-network provider fee is by definition *not* the usual fee charged by physicians in any given market. The whole purpose of assembling a network of preferred health providers is to allow the insurer to cover its beneficiaries' expenses on a negotiated schedule below the prevailing market rate. We agree with the analysis of the Eleventh Circuit in *HCA Health:* a reasonable, prudent person would never suspect that the "usual and customary" fee for medical services was synonymous with the lower, contractual fee charged by an insurer's in-network physicians. Such an interpretation renders "usual and customary" virtually meaningless.

United's interpretation has the effect of misleading Plan members and denying them necessary medical coverage. Given its departure from industry custom and its deleterious effect on Plan beneficiaries, we find United's interpretation of "usual and customary" arbitrary and capricious. We agree with the district court that "usual and customary" in this instance means the prevailing market rate. We affirm the district court's order directing United to pay the Geddeses' St. Mary's Hospital invoices as billed.

### D. Everest's Liability under the Statute

We come finally to Defendant Everest's belatedly-raised argument that the district court lacked authority under 29 U.S.C. § 1132(d)(2) to order a money judgment against it. Because the issue was not raised below, we may consider it here only if the argument is purely a matter of law whose proper resolution is certain. *United Steelworkers of Am. v. Or. Steel Mills, Inc.*, 322 F.3d 1222, 1228 (10th Cir. 2003) (quoting *Ross v. United States Marshal for E. Dist. of Ok.*, 168 F.3d 1190, 1195 n.5 (10th Cir. 1999)). We believe it is. The ERISA statute is clear: ERISA beneficiaries may bring claims against the plan as an entity and plan administrators. Everest is neither. We reverse the district court.

We predicate our analysis on the district court's conclusion that Everest Administrators is not a fiduciary under the terms of the ERISA statute. *See* Subsection II.A n. 1, *supra*. No party to this action argues to the contrary. Under these circumstances, we decline here to revisit that factual conclusion.

The language of 29 U.S.C. § 1132(d)(2) allows beneficiaries to bring claims against the plan entity, and possibly against plan administrators and named fiduciaries as well. The statute provides:

> Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

*Id.*

The circuits are divided on whether beneficiaries may bring claims against plan administrators and named fiduciaries in addition to the plan entity. But no circuit holds that a non-fiduciary such as Everest is liable under the terms of 29 U.S.C. § 1132(d)(2). *Compare Riordan v. Commonwealth Edison Co.*, 128 F.3d 549, 551 (7th Cir. 1997) ("It is true that ERISA permits suits to recover benefits only against the plan as an entity. . . .") *and Lee v. Burkhart*, 991 F.2d 1004, 1009 (2d Cir. 1993) (quoting *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324 (9th Cir. 1985) ("ERISA permits suits to recover benefits only against the plan as an entity.")), *with Curcio v. John Hancock Mut. Life. Ins. Co.*, 33 F.3d 226, 233 (3d Cir. 1994) (stating that ERISA permits suits to recover benefits against the plan as an entity and against the fiduciary of the plan); *Daniel v. Eaton Corp.*, 839 F.2d 263, 266 (6th Cir. 1988) (holding that the proper party in an ERISA action concerning benefits is the party "shown to control administration of the plan").

This makes sense in light of traditional trust principles, as applied to the architecture of ERISA plan administration. The statute requires that plan administration be vested in a fiduciary, and permits the fiduciary plan administrator to employ an agent to carry out plan responsibilities. The fiduciary owes a duty of care to the beneficiaries, and is legally responsible both for its own decisions and also for decisions made by its agent. *Cook v. Holland,* 575 S.W.2d 468, 472 (Ky. Ct. App. 1978); *In re Estate of Lohm's Estate,* 269 A.2d 451, 455 (Pa. 1970); *In re Hartzell's Will,* 192 N.E.2d 697, 706 (Ill. App. Ct. 1963); *Kenny v. Citizens Nat. Trust & Savings Bank of Los Angeles,* 269 P.2d 641, 652 (Cal. Ct. App. 1954); Restatement (Second) of Trusts § 225. The agent, however, assuming it is not a fiduciary, owes duties to the administrator and not to the beneficiaries.

As an independent, non-fiduciary, third party administrator, Everest might still be liable under the statute if the Geddeses had made claims against Everest individually, distinct from its role as United's agent. But they did not. Nor did the district court find any basis for personal liability against Everest. For these reasons, the money judgment against Everest is reversed.

## III. Conclusion

We **REVERSE** the district court's judgment as to the Primary Children's claims and remand for reconsideration on the administrative record, on an "arbitrary and capricious" standard of review. We **AFFIRM** the district court's refusal to consider United's belated pre-certification argument. We **AFFIRM** the district court's judgment as to

the St. Mary's claims against United. We **REVERSE** the district court's money judgment against Everest.

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No. 05-4142, *Michael Geddes, et al. v. United Staffing Alliance Employee Medical Plan, et al.*

**HOLLOWAY**, Circuit Judge, concurring in part and dissenting in part:

I respectfully dissent from the holding that the benefits determinations should be reviewed under the arbitrary and capricious standard. I therefore dissent from Parts II-A and II-B of the majority opinion, and I concur only in the result as to Part II-C. I concur in Part II-D, agreeing that the court should notice and reverse the error of entering judgment against defendant Everest.

I

First, I disagree with the majority's framing of the issue as "whether a fiduciary's decision to delegate part of its *Firestone* authority to an independent claims administrator triggers *de novo* review." Maj. op. at 2. The question instead is simply whether any discretion was exercised to which the courts owe deference. I believe that on this record the answer to that question is clearly no. In this case, the fiduciary party with discretion (United) did not act, and the party which acted (claims administrator Everest) had no discretion. The majority's holding, which is in effect that *any* act authorized by a party vested with discretion must be reviewed with deference, is contrary to – rather than dictated by – the common law of trusts, is contrary to the manifest intent of Congress for ERISA

plans to be administered by a fiduciary, and creates a circuit split by adopting its unprecedented holding.

The majority's analysis is critically flawed because its underpinning is the unsupported assumption that "discretion was exercised by some combination of the fiduciary and its agent." Maj. op. at 13. As I will demonstrate *infra*, any suggestion that the agent exercised discretion is not supported by the evidence concerning how the claims were handled and is directly contrary to the contractual provision governing the relationship between the fiduciary and the agent. Further, both the fiduciary and the agent specifically denied in their pleadings, under constraints of Fed. R. Civ. P. 11, that the agent exercised any discretion. And the record is clear that the fiduciary, United, did nothing at all. Consequently, the majority's naked assertion that some combination of the fiduciary and its agent exercised discretion is simply that – a naked assertion completely lacking in support.

## II

Before outlining the facts and circumstances that refute the majority's key assumption, I think it useful to briefly state the relevant legal principles. We said in *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 631 (10th Cir. 2003), that to be entitled to deferential review, the administrator must actually exercise the discretion granted by the plan. The district court applied the plain meaning of that statement and others from *Gilbertson*, including this:

> "[I]f a trustee fails to act or to exercise his or her discretion, *de novo* review is appropriate because the trustee has forfeited the privilege to apply his

> or her discretion; *it is the trustee's analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer.*"

*Gilbertson*, 328 F.3d at 633 (quoting *Gritzer v. CBS, Inc.*, 275 F.3d 291, 296 (3d Cir. 2002)) (emphasis added). I agree with the district court that this language should be applied to the circumstances here where the administrator only acted through the agent, which had neither discretion nor fiduciary duties.[1] No party exercised the discretion granted by the plan; therefore, the plan administrator is not entitled to deferential review. This seems in keeping with the common law of trusts: "Where discretion is conferred upon the trustee . . . *its exercise* is not subject to control by the court, except to prevent an abuse by the trustee of his discretion." Restatement (Second) of Trusts § 187 (1959) (emphasis added). Failure to use judgment is by definition an abuse of discretion. *See id.* at comment e.

The other circuits that have considered this issue have reached this same conclusion. *See Rodriguez-Abreu v. Chase Manhattan Bank*, 986 F.2d 580, 584 (1st Cir. 1993) ("To be an effective delegation of discretionary authority so that the deferential standard of review will apply, therefore, the fiduciary must properly designate a delegate for

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[1] The critical legal premise of the majority opinion, it appears, is the conclusion that 29 U.S.C. § 1105(c)(1) permits the delegation of non-fiduciaries to carry out fiduciary responsibilities. Maj. op. at 9-10. As shown *infra*, no factual basis exists for application of this conclusion of law in this case where only ministerial duties were delegated. Moreover, the conclusion is wrong as a matter of law. Under ERISA, if a party exercises discretion, it *is* a fiduciary. 29 U.S.C. § 1002(21)(A). *See also Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288, 291 (11th Cir. 1990) ("[I]t is clear that an administrator with discretionary authority *is* a fiduciary.") (emphasis in original).

the fiduciary's discretionary authority."); *Madden v. ITT Long Term Disability Plan*, 914 F.2d 1279, 1283-85 (9th Cir. 1990) ("[W]e hold that where . . . a named fiduciary properly designates another fiduciary, delegating its discretionary authority, the 'arbitrary and capricious' standard of review . . . applies. . . ."); and *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288, 291 (11th Cir. 1990). *See also Nichols v. Prudential Ins. Co.*, 406 F.3d 98, 109 (2d Cir. 2005) ("[W]e conclude that we may give deferential review only to actual exercises of discretion.").

The majority opinion relies heavily on its reading of the statutory provision authorizing delegation of duties. That provision states, in pertinent part:

> The instrument under which a plan is maintained may expressly provide for procedures (A) for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries, and (B) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan.

29 U.S.C. § 1105(c)(1).[2]

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[2] It appears to me that a line was inadvertently dropped in the district court's quotation from this statute and that the district judge meant to quote the relevant parts of the provision just as the majority opinion does. This seems likely to me for two reasons. First, the district court opinion introduces its abbreviated quote from the statute by saying that ERISA provides that a named fiduciary may delegate its fiduciary responsibilities. But the provision as quoted in the district court opinion does not say that at all. In fact, the edited version that appears in that opinion merely states what is, under ERISA, a truism: that the plan may provide for named fiduciaries to carry out fiduciary responsibilities. Second, the district judge goes on to discuss with

(Continued on following page)

In this case, *there was no designation* of any other person *to carry out fiduciary responsibilities. I do not* doubt that the named fiduciary may, as United did here, also designate another, Everest in this case, to carry out ministerial functions. *See* 29 C.F.R. § 2509.75-8, D-2. Or, as in *Madden,* the named fiduciary may designate another fiduciary to perform discretionary duties, and *discretionary* decisions by the designated fiduciary will be reviewed deferentially. But it is precisely because ministerial, and not discretionary or fiduciary, duties were delegated – combined with the key fact that United did not exercise its retained discretionary authority – that no deference is due the decisions made.[3]

I realize that United's delegation of duties to Everest does not relieve it of liability because it is bound by the acts of its agent, as the majority opinion notes. But surely

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apparent approval the holding of *Madden* that where "a named fiduciary properly designates *another fiduciary,* delegating its discretionary authority, the 'arbitrary and capricious standard' . . . applies to the designated ERISA-fiduciary as well as to the named fiduciary." This discussion also is inconsistent with the truncated version of the statutory provision as quoted in the district court's opinion.

[3] The majority opinion says that the fact that Everest handled every claim "led the district court to conclude that United Staffing effectively did nothing, totally failing for purposes of the ERISA statute and *Gilbertson* to exercise its discretion and thereby forfeiting its claim to deferential review." Maj. op. at 9. But the district court did not merely draw an inference that United did nothing. The evidence was clear and undisputed, and based entirely on the deposition testimony of United's representative, that United did nothing. The question is whether a fiduciary which has reserved to itself all fiduciary obligations and all discretion and then does nothing should be afforded the same deferential review that we would give to the decisions of a fiduciary which actually exercised its reserved discretion to make the final determinations on contested claims.

this statute's purposes go beyond ensuring that someone *can be held liable through court action.*

Under the ERISA scheme, a plan administrator exercises the function of handling claims with fiduciary responsibilities to the plan's beneficiaries. This seems to be close to the very heart of the legislative plan: "It is hereby declared to be the policy of this chapter to protect . . . the interests of participants in employee benefit plans and their beneficiaries, by . . . establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans. . . ." 29 U.S.C. § 1001(b).

More importantly, the issue here is not whether United may be liable for Everest's actions undertaken as United's agent. Of course United may be so liable. The issue instead is whether, in deciding whether liability should be imposed in this case, the court should review the decisions deferentially. And there is simply no basis shown for such deference where the decisions were ministerial, rather than discretionary, in character. In this case the fiduciary clearly failed to exercise its discretion and instead simply defaulted to the non-fiduciary agent, which expressly was not endowed with discretion, to carry out duties that ERISA assigns to a fiduciary. Because no discretion was exercised, no deference is due to the decisions made. In the alternative, however, I would hold that the decisions as to the Primary Children's Hospital claims which were handled in this perfunctory fashion were arbitrary and capricious. The following discussion illustrates both that the acts were not discretionary and that the decisions were arbitrary and capricious.

## III

I disagree that the majority's result is supported by our decision in *Gilbertson,* but it is useful to note the factual differences in the cases. We noted in *Gilbertson* that the plan administrator had delegated its *discretion* to the third-party claims administrator and that the plan documents expressly authorized such delegation. But this case is quite different. In this case the plan document provided:

> The Company is the *named fiduciary* and is the *plan administrator* of the Plan. The Company will engage an independent *claims administrator* to administer the Plan, however, the Company makes all final decisions about benefits paid from the Plan.

Aple. Supp. App. 250 (italics in original). This is not language delegating discretionary authority or fiduciary responsibilities. *See Nichols v. Prudential Ins. Co.,* 406 F.3d 98, 108-09 (2d Cir. 2005) (discussing language that is effective to vest discretion in an administrator).

Moreover, the defendants in this case have resolutely and consistently taken the position that Everest exercised no discretion and was not a fiduciary. Both specifically denied in pleadings that Everest was vested with discretion. In the Complaint, plaintiffs had alleged on information and belief that both United and Everest had discretionary authority. Aple. Supp. App. 3, ¶ 12. Both defendants specifically denied the allegation. *Id.* at 12, 19.

The contract under which Everest acted was quite clear on the point:

> The Contract Administrator [Everest] shall not be deemed a Plan "fiduciary" as defined in ERISA.

> [Everest's] services shall not include any power to make decisions regarding Plan policy, interpretations, practices or procedures, but *shall be confined to ministerial functions* such as those described by the U.S. Department of Labor in its Regulations Section 2509.75-8, D-2. . . . *[Everest] shall have no final discretionary control* over Plan management, including disposition of Plan assets and Plan administration. [Everest's] services hereunder shall be subject to review, modification, or reversal by the Plan Sponsor and/or Plan Administrator.

*Id.* at 271 (emphasis added).

As to the claims for Andrew's treatment at Primary Children's Hospital, the subject of Part II-B of the majority opinion, the deposition testimony of the witness designated to speak for Everest further reveals the ministerial or clerical nature of Everest's services. The witness testified that the process of reviewing the claims for Andrew's treatment at that hospital consisted almost entirely of reading the numerical code used by the hospital to categorize the service and comparing that with the plan's coverage language:

> Q. Now, when a claim would come in under this plan, give me an idea of how it was decided whether the claim would be paid, how much would be paid, or whether it would be denied.
>
> A. The basis for doing that is, of course, the provisions of the master plan document and the way that the care is coded or represented by the care provider.
>
> There are universal codes, diagnosis codes, service codes that are used in the medical care

field. And those codes are required to be on the bill. If they're not, then we are not able to process the bill. . . . And those codes are a way that the care provider themselves represents what the care provided was, what classification, what category of care it was. And from those codes we can determine which category on the schedule of benefits is the one that applies.

Again, it's a matter of correctly inputting the care codes in the claims administrator system. And that gives the claims administrator the information they need to categorize the care.

Once the care is categorized, then the schedule of benefits dictates how the benefit payment is made. . . .

. . . .

But I think it's a pretty good summary of what happens to say that it's a matter of taking the codes that the care provider has assigned to the care they provided. That helps us categorize the care. And then from then – from that point on, the master plan document dictates what benefit is payable by the plan.

* * * *

Q. So then who makes the determination after that of the category that that particular type of service falls into?

A. Almost without exception, the provider of care has categorized the service that they have provided by coding it in a certain way. So – when you use the term judgment, to me, that means that there's some sort of judgment decision to make. And for the most part, that's not the case. It's a matter of simply – of correctly reading what

> the care provider codes are and putting it in the correct – putting it in the category that the care provider has assigned it to.

*Id.* at 401-04 (testimony of Ronald C. Hulse).

This is, so far as I can determine, the best description available of how the claims for care at Primary Children's Hospital were handled. The hospital chose to use the numerical code for rehabilitative services rather than the code for services connected with hospitalization for most of the services provided. Rehabilitative services were limited under the plan to $2,500.00. Everest read the codes used by the hospital and mechanically applied the limitation stated in the plan. This is the "exercise of discretion" to which, the majority holds, deference is required.

Because I disagree with the fundamental premise that discretion was exercised by Everest as agent for United, I see no basis for employment of the deferential standard of review. I therefore respectfully dissent from the holdings in Parts II-A and II-B of the majority opinion and would affirm the district court's judgment on the claims involving care provided at Primary Children's Hospital.[4] I concur in the result of Part II-C, which affirms the district court's judgment on the claims involving care provided at St. Mary's Hospital, but for the reasons set out herein I would

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[4] After holding that the *de novo* standard of review applied because the delegation of responsibilities was to a non-fiduciary and no fiduciary ever reviewed the Geddes' claims, the district judge noted that his holding made it unnecessary to determine whether the *de novo* standard should be applied for another reason – the Geddes' allegation that the administrator failed to follow its claims and appeals procedures. I feel it appropriate to note that the district court is free to address that issue on remand.

reach that result by affirming the district court's analysis under *de novo* review rather than by re-examining the claims under the arbitrary and capricious standard.

## IV

For the reasons stated in Part II-D of the majority opinion, I agree that the monetary judgment against Everest should be reversed.

APPENDIX B

2005 WL 1414268

IN THE UNITED STATES COURT
FOR THE DISTRICT OF UTAH

CENTRAL DIVISION

| | |
|---|---|
| MICHAEL GEDDES and KARI GEDDES individual and as guardians of ANDREW GEDDES, a minor child,<br><br>Plaintiffs,<br><br>vs.<br><br>UNITED STAFFING ALLIANCE EMPLOYEE MEDICAL PLAN; U.S.A. UNITED STAFFING ALLIANCE, L.L.C., a limited liability company and EVEREST ADMINISTRATORS, INC., a Utah corporation,<br><br>Defendants. | MEMORANDUM OPINION GRANTING PARTIAL SUMMARY JUDGMENT TO PLAINTIFFS<br><br>Case No. 2:03-CV-00440 PGC<br><br>(Filed March 23, 2005)<br><br>Judge Paul G. Cassell |

Plaintiffs Michael, Kari, and Andrew Geddes, and defendants U.S.A. United Staffing Alliance, L.L.C., and Everest Administrators (collectively "United Staffing") have filed cross-motions for summary judgment on the Geddes's three pending Employment Retirement Income Security Act (ERISA) claims. The court has reviewed the pleadings and GRANTS the Geddes' motion for summary judgment on the first cause of action and GRANTS United

Staffing's motion for summary judgment on the Geddes' second and third causes of action.

## BACKGROUND

On June 27, 2002, Andrew Geddes dove in shallow water at Lake Powell and seriously injured his spinal cord. Andrew lost the ability to move his arms and legs, and his father quickly rescued him. Ultimately, Andrew was transported by air ambulance from Lake Powell to St. Mary's Hospital ("St.Mary's") in Grand Junction, Colorado. The physicians at St. Mary's determined that Andrew had severely injured his spinal cord and placed him in intensive care.

On July 1, 2002, Andrew underwent surgery to repair and align his spine. After surgery Andrew remained in the intensive care unit and a halo device was attached directly to Andrew's skull with pins. The halo device immobilized his spine. Andrew received intravenous hydration and nourishment while at St. Mary's until he left on July 15, 2002.

On July 15, 2002, Andrew was transferred via a five-hour ambulance ride to Primary Children's Hospital in Salt Lake City, Utah ("Primary Children's"). The physicians at St. Mary's requested Andrew be transported by air. United Staffing, however, denied coverage for this mode of transport.

When Andrew arrived at Primary Children's, he was placed in the neuroscience ward. Andrew was still in the halo and had splints on his arms and legs. Throughout his stay at Primary Children's, Andrew received care for complications due to his injuries. Because he was unable

to eat or drink, he was intermittently fed and hydrated. His bladder and bowels were treated constantly. He was given enemas and catheters daily to prevent dysreflexia, a potentially deadly condition common in paralysis victims. He also received extensive rounds of medication for such things as pain control, bowels, bladder, infections, and spasticity. Throughout his stay, medical personnel also provided respiratory and radiological services. Primary Children's did not discharge Andrews [sic] from inpatient care until September 10, 2002.

Andrew's treating physician at Primary Children's – Dr. Terese Such-Neibar – stated that spinal cord injuries, such as Andrew's, typically require two months of inpatient care. She also concluded Andrew needed to remain at Primary Children's's [sic] until September 10, 2002, and could not have been released earlier.

***The Plan***

The Geddes were enrolled in the United Staffing Alliance Employee Medical Plan (the "Plan"). The Plan is an employee welfare benefit plan as defined under ERISA[1] and its terms are defined in the Summary Plan Description (also referred to as the "Plan"). The parties agree that Andrew was a covered dependent under the Plan at the time of the accident.

Defendant United Staffing is a fiduciary to the Plan[2] and provided copies of the Master Policy Description to the Geddes in 2002 and 2003. United Staffing contracted with

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[1] 28 U.S.C. § 1000 *et seq.*

[2] 28 U.S.C. § 1104(a) (2000).

a third party administrator, Everest Administrators, to perform the administrative functions of the Plan such as billing, payment, and customer service. Everest Administrators, referred some claims to Intracorp for review as well – Intracorp is another independent claim administrator delegated by United Staffing to review submitted claims. The Plan stated that *United Staffing* made all of the "final decisions about benefits paid from the Plan."[3]

The Plan states:

> The Plan will give the Participant *written* notice of any claim that is denied in whole or in part, listing the specific reasons for the denial. . . . If a Participant is not satisfied with the explanation of why payment was denied, the Participant can request that the claim be reviewed. . . . The Company will have the responsibility to make all final determinations regarding the claims for benefits under the Plan, and will have the right to interpret the terms and provisions of the Plan.[4]

While the Plan clearly states that "[t]he company will have the responsibility to make all final determinations regarding the claims for benefits under the Plan," Terry A. Ficklin, a partner owner of United Staffing, testified that United Staffing's role only was to meet annually with Everest to review exclusions and deductibles:

> Q: So if I understand what you are saying, [United Staffing] met with Everest and

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[3] Memorandum in support of Motion for Summary Judgment, Exhibit 3, p.1.

[4] *Id.*

[United Staffing] determined the exclusions, correct?

A: Correct, on an annual basis.

Q: Right, and you determined things like deductibles? Is that correct?

A: Deductibles, yes.

Q: On an annual basis?

A: Prices.

. . .

Q: . . . So when you say United Staffing makes all final decisions about benefits paid from the plan, that's what you are referring to is those annual determinations?

. . .

A: Yes, that's my understanding of what that meant when they explained that part to me. . . .

Q: Okay. So United Staffing never sits down and reviews a claim from a plan participant to determine whether the claim is going to be covered or not?

A: We do not. Never have.

Q: That's Everest's responsibility, correct?

A: Yes.[5]

Through Everest, United Staffing contracted with care providers to provide services to plan participants at a

[5] Depo. of Terry A. Ficklin ("Ficklin Depo."), p. 31-32.

discounted contract price ("Network Providers"). The Plan also provided coverage for care given by out of network providers. Specifically, "[f]or services provided by a non-participating provider," the Plan paid "the usual and customary amount as determined by the Plan."[6]

The Plan also defined several relevant terms:

> **In-patient treatment** – receiving care in a hospital or other facility provider as a registered patient and incurring a room and board charge.[7]
>
> **Hospital** – An institution which is engaged primarily in providing medical care to sick and injured persons on an in-patient basis, is appropriately licensed by the regulatory authority having jurisdiction, and is accredited by Joint Commission on Accreditation of Hospitals (JCAH).
>
> **Hospital Care.** Expenses for in-patient and out-patient services and supplies in a hospital. In-patient room and board charges are limited to the semi-private room rate. Hospital confinement primarily for physiotherapy, hydrotherapy, intravenous drug administration, convalescent care, or rest care are not covered.

***Payment of Claims***

St. Mary's billed the Geddes $86,460.70 for Andrew's care. United Staffing only paid $37,363.66 of these charges. Primary Children's billed the Geddes $99,431.98 for Andrew's care. United Staffing only paid $3,557.66 of

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[6] *Id.* at 28.

[7] *Id.* at 31.

these charges for lab work, X-rays, and other items during Andrew's stay. As an explanation, Everest sent standard claim form denials to the Geddes. One notice of denial of benefits stated that the claim was denied because the Geddes' annual limit of a certain category of service (rehabilitation) had been met. A second explanation of benefits stated that the claims were denied because they involved "In-patient Rehab or SNF (facility)."

On August 5, 2002, a letter from Everest stated that Intracorp had reviewed the claims. The letter explained the reason for continued denial somewhat cryptically as:

> Noncertify continued stay 7/11 through discharge. Rationale: Information provided does not establish medical necessity for acute in-patient hospital care on above dates of service.

This letter invited the Geddes to appeal the decision. The letter specifically stated:

> In order for Intracorp to process an appeal, the following information must be provided to Intracorp by the treating physician:
>
> – Clinical reason for the requested service; and
>
> – Any other information that supports the request.
>
> The attending physician or requesting provider can provide this information telephonically if admissions/services are ongoing, or in writing if admissions/services have been discontinued. Please submit the appeal request, any additional clinical information, or questions related to this

> process to Intracorps's Appeal Coordinator at the above address and telephone number.[8]

The letter was signed by Dr. James Finke M.D., Physician Advisor, and did not list whether Dr. Finke worked for Intracorp or Everest. Confusingly, the letter listed the addresses of Everest Administrators and Intracorp at the top of the first page. On the top of the first page, Ms. Roberta Zumdahl was listed as the appeals coordinator at Intracorp.

On September 17, 2002, the Geddes sent a letter to Intracorp addressed to Ms. Roberta Zumdahl. The letter stated "I am officially appealing this decision . . . " and discussed the Geddes' contentions that the Plan did cover Andrew's care at Primary Children's because he needed "Acute In-Patient Hospital Care."[9] Neither Ronald Hulse (the president of Everest) nor Mr. Ficklin denied receiving this letter. Mr. Geddes indicates under oath he in fact sent this letter.[10]

Eventually on January 29, 2003, Mr. Hulse of *Everest* sent a response to the Geddes' attorney discussing the "request for reconsideration."[11] The letter stated, "We completely agree that the rehabilitation care was medically necessary."[12] Nonetheless, Everest denied the request for reconsideration based on the fact that, "Limits on long-term

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[8] Plaintiff's Memorandum in Support of Motion for Summary Judgment, Ficklin Deposition, Exhibit 7.

[9] *Id.*, Exhibit 9.

[10] *Id.*, Geddes Declaration, ¶ 12.

[11] Defendant's Memorandum in Support of Motion for Summary Judgment, Declaration of Lawrence Buhler, Exhibit L.

[12] *Id.*

rehabilitation care are almost universal."[13] The Geddes then filed suit, asserting three claims: (1) violation of ERISA §§ 502(a)(1)(B) and 502(a)(3), (2) breach of fiduciary duty – a violation of ERISA §§ 404(a) and 502(a)(3), and (3) violation of ERISA § 502(c)(1)(B). Soon thereafter, both parties filed cross motions for summary judgment.

## SUMMARY JUDGMENT STANDARD OF REVIEW

Pursuant to Rule 56 of the Federal Rules of Civil Procedure, summary judgment "shall be rendered . . . if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits . . . show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law."[14] In applying this standard, the court must examine the evidence and reasonable inferences therefrom in the light most favorable to the non-moving party.[15]

## STANDARDS OF REVIEW FOR ERISA CLAIMS

Although ERISA, in 29 U.S.C. § 1132(a)(1)(B), allows plaintiffs "to recover benefits due under the [insurance] plan, to enforce rights under the terms of the plan, and to obtain a declaratory judgment of future entitlement to benefits under the provisions of the plan contract,"[16] nowhere do the ERISA statutes provide a judicial standard of review for such claims. The Supreme Court has filled

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[13] *Id.*

[14] Fed. R. Civ. P. 56(c).

[15] *See Gaylor v. Does*, 105 F.3d 572, 574 (10th Cir. 1997).

[16] *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 108 (1989) (citing 29 U.S.C. § 1132(a)(1)(B)).

this void by holding in *Firestone Tire and Rubber Co. v. Bruch* in 1989 that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard *unless* the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[17] When an insurer retains discretionary authority, the insurer's interpretation and decision must be upheld "unless it was arbitrary and capricious."[18]

Notwithstanding the standard set forth in *Firestone*, "[t]o be entitled to deferential review, not only must the administrator be given discretion by the plan, but the administrator's decision in a given case must be a valid exercise of that discretion."[19] In *Gilbertson v. Allied Signal, Inc.*, the Tenth Circuit found that the plan's administrator was not entitled to a deferential standard of review because the company "never got around to exercising its discretion or applying its administrative expertise to reach a final decision."[20] Therefore, "if 'a trustee fails to act or to exercise his or her discretion, *de novo* review is appropriate because the trustee has forfeited the privilege to apply his or her discretion; it is the trustee's analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer.' "[21]

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[17] *Id.* at 115 (emphasis added).

[18] *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996).

[19] *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 631 (10th Cir. 2003).

[20] *Id.* at 636.

[21] *Id.* at 633 (quoting *Gritzer v. CBS, Inc.*, 275 F.3d 291, 296 (3rd Cir. 2002)).

During the summary judgment hearing held before the court, all parties agreed that Everest – the company to which United Staffing delegated its authority to review and evaluate claims – was not a fiduciary and had no fiduciary duties to the Geddes. In fact, when counsel for United Staffing inferred that Everest owed fiduciary duties to the Geddes, counsel for Everest quickly corrected counsel by making clear that it is not a fiduciary to the Geddes. United Staffing's counsel agreed. This is also reflected in the contract between United Staffing and Everest. The service agreement specifically states that Everest is not to be a fiduciary and that it is not to be the party responsible for making final benefits determinations. Furthermore, there is no evidence that United Staffing ever reviewed any of Geddes's claims. Because Everest was the only party that reviewed Geddes's claims, and because it is undisputed that Everest is not a fiduciary to the Geddes, the court finds that at no point did a fiduciary for the Geddes ever evaluate their claims. Consequently, because the fiduciary in this case – United Staffing – opted not to exercise its self-delegated discretionary authority, it is presumed to have waived its right to deferential review as held by the Tenth Circuit in *Gilbertson*.[22] A brief explication of this conclusion may be appropriate.

Under ERISA, "[e]very employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more *named fiduciaries* who jointly or severally shall have authority to control and manage the operation and administration of

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[22] *Gilbertson*, 328 F.3d at 633.

the plan."[23] ERISA further provides that a named fiduciary may delegate its fiduciary responsibilities: "The instrument under which a plan is maintained may expressly provide for procedures . . . (B) for *named fiduciaries to carry out fiduciary responsibilities* . . . under the plan."[24]

As defined by the Plan:

> [United Staffing] is the *named fiduciary* and is the plan administrator of the Plan. [United Staffing] will engage an *independent* claims administrator to administrate the Plan, however, [United Staffing] makes *all final decisions* about benefits paid from the Plan.[25]

Additionally, the appeals section of the Plan clearly states that United Staffing "will have the responsibility to make all final determinations regarding claims for benefits under the Plan, and will have the right to interpret the terms and provisions of the Plan."[26] And lastly, in that same section, United Staffing reiterates its role as fiduciary: "The people who operate this Plan are called 'fiduciaries' of the Plan, and they have a duty to operate the Plan prudently and in the interest of Plan Participants."[27]

For deferential review of a discretionary decision to apply, the party delegated the responsibilities to review claims should also be a named fiduciary. In the Ninth Circuit case of *Madden v. ITT Long Term Disability Plan*

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[23] ERISA, 29 U.S.C. § 1102(a)(1).

[24] ERISA, 29 U.S.C. § 1105(c)(1) (emphasis added).

[25] Plan, p. 1 (emphases added).

[26] Plan, p. 34.

[27] Plan, p. 35.

*for Salaried Employees,*[28] the insurance provider (ITT) delegated its fiduciary duties to Metropolitan Life Insurance Company. After Madden submitted a claim, Metropolitan reviewed Madden's file and responded by terminating Madden's benefits.[29] At Madden's request, Metropolitan reviewed its own decision and reaffirmed its decision to terminate benefits.[30] Later, again at the request of Madden, Metropolitan conducted another review, this time by requesting an independent outside agency to perform its own assessment – the decision was the same.[31] In holding that Metropolitan's decisions were subject to deferential review, the Ninth Circuit explained:

> In accordance with the logic and reasoning of *Firestone,* we hold that where (1) the ERISA plan expressly gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan and (2) pursuant to ERISA . . . a named fiduciary properly designates *another fiduciary,* delegating its discretionary authority, the 'arbitrary and capricious standard of review for ERISA claims brought under § 1132(a)(1)(B) applies to the designated ERISA-*fiduciary* as well as to the named fiduciary.[32]

While this holding is helpful to insurance providers who delegate some of their responsibilities, it does not apply here in light of the undisputed fact that Everest is

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[28] 914 F.2d 1279, 1281 (9th Cir. 1990), *cert. denied,* 498 U.S. 1087 (1991).

[29] *Id.* at 1281-82.

[30] *Id.* at 1282.

[31] *Id.*

[32] *Id.* at 1283-84.

not a fiduciary. In *Madden,* it was important that "the Plan named ITT as Plan administrator and fiduciary and expressly authorized ITT's Board of Directors to appoint a Long-Term Disability ("LTD") Administration Committee to have responsibility for carrying out all phases of the Administration of the Plan."[33] Furthermore, in that case "[t]he Plan, as permitted by § 1105(c)(1), also expressly authorizes the LTD Administration Committee to designate another person *as fiduciary* for the administration of the Plan[.]"[34] Specifically, the key language of the Plan stated:

> The LTD Administration Committee may delegate its authority with respect to the denial, granting, and administration of claims to a claim administrator, which may be an insurance company or other appropriate *named fiduciary* and may enter into a Claims Administration Agreement with such claim administrator for the handling and determination of claims including, but not limited to, the granting or denial of claims and any appeals therefrom.[35]

In determining whether ITT appropriately delegated *fiduciary* responsibilities to Metropolitan, the court looked to the Claims Administrative Agreement entered into between ITT and Metropolitan:

> Upon receipt of a claim, Metropolitan shall review the claim including evaluation by Metropolitan's consultants when required, and determine whether it has been properly filed and the

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[33] *Id.* at 1284 (internal quotations omitted).

[34] 914 F.2d at 1284 (emphasis added).

[35] *Id.* (emphasis in original omitted; emphasis added).

> amount, if any, which is due and payable with respect thereto. In making benefits payments, Metropolitan will determine the validity of each claim presented and will, as necessary, make appropriate investigations within the time prescribed for processing of claims. . . .
>
> . . . .
>
> If benefits are to be wholly or partially denied, Metropolitan shall notify the claimant within a reasonable period of time. . . . *Metropolitan will have fiduciary responsibility for provision of full and fair review of claim denials.* . . . Final determination of payment or denial of appealed claims will be made following appropriate analysis and review.
>
> . . . .
>
> [I]n the event ITT determines that Metropolitan has misinterpreted the Plan and so informs Metropolitan in writing of such appropriate interpretation, and such interpretation is deemed not unreasonable and not inconsistent with the terms of the Plan to Metropolitan, all claims processed after delivery of such writing to Metropolitan shall be administered in accordance with the interpretation of ITT.[36]

After examining ERISA, the Plan, and the Claims Administration Agreement, the Ninth Circuit held that "[b]ecause the Plan gives the LTD Administration Committee discretionary authority and the Committee has *properly designated Metropolitan as ERISA fiduciary,* we review Metropolitan's decision to terminate Madden's Plan

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[36] *Id.* at 1284-85 (emphasis in original).

benefits under the more deferential 'arbitrary and capricious' standard."[37]

This case is quite distinguishable because of the plain language of the Plan at issue here. The Claim Administration Agreement entered into by Everest and United Staffing lacks comparable language delegating fiduciary responsibilities to a third party. The contract clearly states that Everest is *not* a fiduciary, nor is it responsible for making final decisions.

The court has found one case in which a non-fiduciary's decision to deny benefits was reviewed under the "arbitrary and capricious" standard. That case, however, is wholly distinguishable from this one. In *Dinote v. United of Omaha Life Insurance Co.*, the U.S. District Court for the Eastern District of Pennsylvania held that *de novo* review did not apply because, despite the fact that a non-fiduciary physician reviewed the claim, the entire record indicated that the insurance company, "not the non-fiduciary physician, made the final determination to deny Plaintiff's application for . . . benefits."[38] More specifically, instead of denying plaintiff's appeal based solely on the non-fiduciary's report, the insurance company performed another claim review shortly after receiving the report; the insurance company also requested that plaintiff and her doctor submit additional medical information for further consideration of her claim.[39] Based on this evidence, the court held that "[b]ecause the fiduciary *actually made* the final determination . . . , the *de novo* standard of review

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[37] *Id.* at 1285 (emphasis added).

[38] 331 F. Supp.2d 341, 345 (E.D. Penn. 2004).

[39] *Id.*

does not apply, and the arbitrary and capricious standard is used instead."[40]

Unlike the insurance company in *Dinote,* there is no evidence suggesting that the Plan Administrator here (United Staffing) "actually made" the decision to deny the Geddes' claim. United Staffing's partner owner, Mr. Ficklin, made this clear in his deposition testimony:

> Q: So United Staffing never sits down and reviews a claim from a plan participant to determine whether that claim is going to be covered or not?
>
> A: We do not. Never have.[41]

Speaking to the question of whether United Staffing was ever involved in an appeal process of any claim, Mr. Ficklin again said no. Regarding the specific care Geddes received:

> Q: Would it be fair to say that you don't know any of the specifics? And again, when I say you, I am talking about United Staffing, know any of the specifics of the care that he received subsequent to his accident?
>
> A: Not the specifics, to my knowledge.[42]

And finally, regarding simple matters such as how out-of-network versus in-network providers would be treated, Mr. Ficklin, again speaking on behalf of United Staffing, indicated that he had "no idea" how a claim was handled

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[40] *Id.* at 345-46 (emphasis added).

[41] Ficklin Depo., p. 32, at 13-22.

[42] *Id.* at 55-56.

differently depending on whether it was an outside of network provider who had rendered the services that are subject of the claim or whether it was an in-network provider.[43] It is also clear from Mr. Ficklin's deposition that United Staffing had no involvement in determining the "usual and customary" amount paid to out-of-network providers:

> Q: . . . do you know how the plan determined the usual and customary amount that's referred to in that sentence . . . ?
>
> A: I do not.
>
> Q: Again, United Staffing, do they have anything to do with . . . determining the usual and customary amount?
>
> A: We do not.[44]

In sum, the evidence demonstrates without dispute that the final determinations regarding the Geddes' claims were never reviewed by a fiduciary. In light of this finding, the court holds that United Staffing waived its right to deferential review on any of the claims. Notwithstanding, United Staffing's retention of discretionary authority through language in the Plan, this case is covered by the Tenth Circuit's exception to the "arbitrary and capricious" standard of review: *de novo* review is appropriate if an administrator disregards claims and appeals procedures or opts not to exercise its discretion.[45] Based on this conclusion, the court need not determine whether *de novo* review

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[43] *Id.* at 42, 16-24.

[44] Ficklin Depo. p. 44, at 9-18.

[45] *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625 (10th Cir. 2003).

is required because, as the Geddes argue, United Staffing failed to follow its claims and appeals procedures.

## ANALYSIS

While the Geddes' complaint asserted three causes of action, the majority of the briefs and oral argument addressed primarily the first cause of action. Regarding the first cause of action, there are primarily two issues before the court: (1) was it unreasonable for United Staffing to claim that the "usual and customary" amount paid to out-of-network providers (in this case, St. Mary's in Grand Junction, Colorado) is the same amount paid to in-network providers; and (2) whether United Staffing wrongfully denied the Geddes's claim for benefits based on its conclusion that Andrew's stay at Primary Children's in Salt Lake City, Utah was primarily for rehabilitation. Before addressing the St. Mary's and Primary Children's claims, the court will briefly address United Staffing's new argument regarding pre-certification.

### *The Belated-Raised Pre-Certification Issue*

During oral argument on these motions for summary judgment, United Staffing contended that because no pre-certification was given for in-patient hospital care after July 11, 2002 (the date Andrew was transferred to Primary Children's), its denial of benefits was entirely justified. The court believed this was the first time United Staffing had raised this issue. United Staffing, however, insisted that it had raised the pre-certification issue in its briefs. Having again reviewed United Staffing's briefs in search of this pre-certification argument, the court is convinced that at no time before the hearing did United

Staffing present this contention. Moreover, at the oral argument, the court ordered supplemental briefing on the issue of which charges could be easily identified as "rehabilitative." Instead of discussing only that narrow question, United Staffing spent over half of its brief on its newly-raised pre-certification argument. Of course, the orderly presentation of arguments on summary judgment does not allow such belated presentation of an issue. Therefore, because United Staffing waited until its oral argument and post-argument briefs to raise this issue, the court will not consider it. The matter should have been raised in United Staffing's response to the Geddes' motion for summary judgment.[46]

***The Out-of-Network St. Mary's Claims***

United Staffing failed to calculate the allowable amounts for services rendered at St. Mary's in accordance with the Plan's terms. The Plan provides that services for out-of-network providers are covered, but only up to an "allowed amount." The Plan defines the "allowed amount" as "the usual and customary amount determined by the Plan." United Staffing's interpretation of what is "usual and customary" is unreasonable considering that a plan participant would have no reason to anticipate that such language would refer to amounts previously negotiated for and agreed upon with in-network providers.

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[46] *See Charleswell v. Chase Manhattan Bank, N.A.*, 223 F.R.D. 371, 377 (D. VI 2004); *Coke v. Long Island Care at Home, Ltd.*, 267 F. Supp. 2d 332, 336 (E.D.N.Y. 2003); *United States v. Medeiros*, 710 F. Supp. 106, 110 (M.D. Pa. 1989);.

"Under the de novo standard of review, the Court considers the relevant documents in the record to determine the proper interpretation of the disputed provision in [the Plan].[47] The Supreme Court has held that any ambiguities in an ERISA plan must be construed against the employer, as the drafter of the disputed document, in accordance with trust and contract principles of construction.[48] Furthermore, when reviewing the denial of benefits *de novo*, "the burden is on the Defendants to prove that Plaintiffs' interpretation of the [Plan] is unreasonable."[49] And lastly, while the court is limited to the administrative record when conducting a review under the arbitrary and capricious standard, the court may, when reviewing a plan administrator's decision under a *de novo* standard, "supplement the administrative record 'when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision.' "[50]

Immediately after sustaining his injury, Andrew was transferred to St. Mary's in Colorado, an out-of-network provider. St. Mary's billed the Geddes for $86,460.70. In turn, United Staffing paid less than half of the amount billed ($37,363.66), leaving the Geddes responsible to pay the remaining amount. The court must interpret the Plan "as it would any other contract claim by looking to the

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[47] *Rubio v. Chock Full O'Nuts Corp.*, 254 F. Supp.2d 413, 427 (S.D.N.Y. 2003) (citing *Perreca v. Gluck*, 295 F.3d 215, 223 (2nd Cir. 2002)).

[48] *See Firestone*, 489 U.S. at 110-12.

[49] *Rubio*, 254 F. Supp.2d at 428.

[50] *Hall v. Unum Life Ins. Co. of America*, 300 F.3d 1197, 1202 (10th Cir. 2002) (quoting *Quesinberry v. Life Ins. Co. of North America*, 987 F.2d 1017 (4th Cir. 1993)).

terms of the plan."[51] The applicable Plan language defining "allowable expenses" seems straightforward:

> For services provided by a non-participating provider, the usual and customary amount as determined by the Plan.

The problem lies not in the definition, but in the Plan's failure to provide any guidance as to how it will determine what is "usual and customary." Typical practice in the industry is to provide an explanation or schedule of benefits defining what is usual and customary.[52] Without such guidance, a plan participant has no warning of liability until a denial of benefits arrives in the mail.

Cases interpreting similar language have generally involved either a schedule of benefits or some other explanation in the Plan specifically defining these terms.[53] For example, in the Tenth Circuit's case of *Hickman v. Gem Insurance Company,* the plan defined "usual and customary" as "[t]he currently prevailing charge made for a medical service or item by a majority of health care providers of the same discipline [or] type within the same geographical area as determined by the Company."[54] And in *Schwartz v. Oxford Health Plans, Inc.,* decided by the U.S. District Court for the Southern District of New York,

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[51] *Hickman,* 299 F.3d at 1212.

[52] *See id.; Schwartz v. Oxford Health Plans, Inc.,* 175 F. Supp.2d 581, 589 (S.D.N.Y. 2001). *See also* DARCY HITESMAN ET AL., ERISA COMPLIANCE FOR HEALTH AND WELFARE PLANS 268 (2004).

[53] *See Hickman v. GEM Ins. Co., Inc.,* 299 F.3d 1208, 1212 (10th Cir. 2002); *HCA Health Services of Georgia, Inc.,* 240 F.3d 982, 996 (11th Cir. 2001); *Schwartz,* 175 F. Supp.2d at 589.

[54] 299 F.3d at 1210 (emphasis removed).

the policy manual defined "usual, customary and reasonable" ("UCR") as follows:

> A UCR schedule is a compilation of maximum allowable charges for various medical services. They vary according to the type of provider and geographic location. Fee schedules are calculated using data compiled by the Health Insurance Association of America (HIAA) and other recognized sources. What We Cover/reimburse is based on the UCR. . . ."[55]

Without language defining what "usual and customary" means, the ultimate question then becomes whether United Staffing's interpretation is reasonable. United Staffing concedes that the Plan lacked a definition, but argues, essentially, that it has discretion to interpret the clause "usual and customary." United Staffing interprets the "usual and customary" clause to mean payment at discounted in-network rates rather than what most insurance companies interpret it to mean (amounts determined by comparing similar services in an applicable geographic area).

The court finds United Staffing's interpretation is unreasonable. The Eleventh Circuit has helpfully analyzed this issue.[56] Discussing what is "usual and customary," the Circuit explained that "[a] prudent person . . . . would not consider a discounted fee [to be usual and customary] because it only arose out of a *specified contractual relationship*. The usual and customary fee is the reasonable fee and, as such, is the fee recognized by a prudent

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[55] *Schwartz*, 175 F. Supp.2d at 583.

[56] *HCA Health Services*, 240 F.3d at 996-98.

person."[57] The Circuit was not interpreting the phrase "usual and customary" as it existed in the plan, but instead was using "usual and customary" to arrive at a sensible definition of an ambiguous term within the plan. Nonetheless, the Circuit's analysis is persuasive as applied to this case. The Eleventh Circuit went so far as to determine that payment of a discounted rate to providers who had not negotiated such rate was arbitrary and capricious.[58] The court expressed concern that paying out-of-network providers at the same rate as in-network providers ultimately would deleteriously affect plan participants.[59] Explaining this point, the court reasoned that the interpretation of "usual and customary" as in-network would in effect turn a discounted fee negotiated between a specific provider and a specific insurance company into the usual and customary fee for the entire medical industry.[60] This court agrees. In the absence of some explanation, guidance, or definition of "usual and customary" as applied to the Plan, United Staffing's approach of paying out-of-network providers the same discounted rate it has contractually arranged to pay in-network providers is an unreasonable interpretation of the Plan's plain language.

The question then arises as to what is the reasonable interpretation of usual and customary. The Geddes argue that the billed amount was the usual and customary amount, and United Staffing has placed all its eggs in the in-network basket. Accordingly, the court must agree with the Geddes' position. United Staffing is directed to cover

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[57] *Id.* at 997.

[58] *Id.* at 1009.

[59] *Id.* at 1008.

[60] *Id.*

the St. Mary's invoices as billed, less (of course) what it has previously paid.

***The Primary Children's Hospital "Rehabilitation" Claims***

The next issue is whether United Staffing properly denied claims from the Geddes for charges incurred at Primary Children's because they were primarily rehabilitative. As explained earlier, the court reviews United Staffing's decision to deny benefits under the *de novo* standard of review. Consequently, the court looks to the plain language of the Plan.

The Plan indicated that "In-patient Hospital Services" were covered at a rate of 80% with no annual limit. On the other hand, the Plan contains a $2,500 annual limit for in-patient hospital care for certain rehabilitative services, specifically "[h]ospital confinement primarily for physiotherapy, hydrotherapy, intravenous drug administration, convalescent care, or rest care are not covered." The dispute in this case, then, boils down to whether Andrew's care was primarily for these specified rehabilitative services.

United Staffing points to the billing codes on the invoices from Primary Children's as the basis for its denial based on its conclusion that Andrew's care was rehabilitative. Some of the billing codes for Andrew's care are within the "97000 range," which apparently indicates the care is rehabilitative. However, this summary assumption ignores the terms of the Plan. It is clear from the undisputed evidence that United Staffing did not review the medical records and instead simply relied upon billing codes on invoices to determine whether to pay benefits. This

simplistic review may be an appropriate "first cut" for plans in determining whether to pay a claim initially; but in a complicated and difficult case such as this, a cursory review cannot reasonably support a final determination.

Calling Andrew's treatment rehabilitative care would be inconsistent with the conclusion of Andrew's treating physician at Primary Children's that his injuries required a two-month in-patient stay. In a recently-submitted declaration, Dr. Terese Such-Neibar confirmed that none of Andrew's care at Primary Children's could have been provided in an alternative setting. United Staffing has argued that the court is not to consider this evidence because it was not presented to United Staffing (or Everest) at the time the denial of coverage was made, but was prepared after the decision to deny benefits had already been made. United Staffing's position is misplaced in light of the court's conclusion that *de novo* review is appropriate. The Tenth Circuit recently considered what is the proper evidentiary scope of review in *de novo* ERISA cases. In *Hall,* the Circuit instructed that district courts could supplement the administrative record in exceptional circumstances in *de novo* ERISA cases because "supplementation would preserve the procedural rights employees were entitled to prior to the enactment of ERISA and 'help protect employees' substantive rights in those limited circumstances where extra-record evidence is relevant and necessary.'"[61] The special facts of this case qualify as the type of limited circumstance referred to in *Hall.* In particular, the medical condition and subsequent treatment are so complex that additional evidence is required for the

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[61] *Graham v. Lincare, Inc.*, 2004 WL 3104821 (D.N.M. Feb. 23, 2004) (quoting *Hall*, 300 F.3d at 1202).

court to effectively undertake its own *de novo* review of whether United Staffing's denial of benefits was justified under the Plan. Moreover, even if the doctor's affidavit was disregarded, substantial evidence nonetheless demonstrates that the primary purpose of Andrew's hospital stay was non-rehabilitative.

The court finds significant that Everest acknowledges it "extensively" reviewed Andrew's medical records and admitted that his care at Primary Children's was "medically necessary."[62] A great deal of Andrew's medical care involved needs that had nothing to do with physiological, hydrotherapy, intravenous medication, or rest care. For three weeks Andrew remained in a halo – a device pinned directly to his skull – to insure stabilization of his spinal cord. Due to frequent vomiting, he intermittently required intravenous feeding. Additionally, Andrew was treated for side effects from the paralysis. The staff monitored Andrew to insure his paralysis did not cause a common, and potentially fatal condition called dysreflexia. He had constant bowel and bladder monitoring. He had on-going respiratory services as well as radiological assessments. And, he had continuing treatment for abnormal involuntary movements. The numerous notes from the nursing staff also confirm Andrew's need for constant monitoring.

Dr. Such-Neibar's assessment of Andrew on his first day at Primary Children's indicated Andrew had a C-R Asia Class C Spinal injury, which had been complicated by a urinary tract infection. Dr. Such-Neibar immediately made numerous recommendations for his care including: bowel program, bladder program, treatment for infectious

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[62] Buhler Declaration, Exhibit L.

disease, treatment for spasticity, pain control, *and rehabilitation.* Even Everest's own computer screen capture notes that the Primary Children's invoices "Diagnosis and Service Codes" regarding Andrew list: Abnormal involuntary movements, other musculoskeletal-symptoms referable to limbs, late effect of spinal cord injury, and other rehabilitation procedure.

A determination that Andrew's *entire* stay at Primary Children's was rehabilitative, however, would be incorrect. The medical records demonstrate that Andrew's in-patient stay at Primary Children's was medically necessary and that the bulk of the expenses were not rehabilitative. But a few of the expenses were rehabilitative. After hearing oral argument in this case, the court ordered both parties to provide supplemental briefing relating to non-rehabilitative expenses. Based on the figures submitted by both parties, of the $99,462.05 in total charges from Primary Children's, $17,804.50 (the amount identified by United Staffing) of that amount is for physical therapy. The court presumes that United Staffing has already paid $2,500 of the $17,804.50 (the amount allowed for rehabilitative services under the Plan). If the court's presumption is wrong, the court orders United Staffing to pay up to that amount. Therefore, with regard to the Primary Children's claim, the Geddes are entitled to a judgment of $81,657.55 (plus any amount owed, up to the policy's $2,500 limit, for rehabilitative services).

***Other ERISA Claims***

In the complaint, the Geddes also claimed that United Staffing breached its fiduciary duties and failed to provide documents in violation of ERISA. Though the Geddes seek

summary judgment on their "ERISA claims," they have raised no arguments in support of these two ancillary claims. Without any opposition to United Staffing's arguments in favor of dismissing these claims, the court GRANTS summary judgment for United Staffing on the Geddes second and third causes of action.

***Attorney's fees***

Under ERISA, a district court "in its discretion may allow a reasonable attorney's fee and costs of action to either party."[63] The Tenth Circuit has set forth a non-exhaustive list of factors that the district court should consider when exercising its discretion to award fees: "(1) the degree of the offending party's culpability or bad faith; (2) the degree of the ability of the offending party to satisfy an award of attorney fees; (3) whether or not an award of attorney fees against the offending party would deter other persons acting under similar circumstances; (4) the amount of benefit conferred on members of the plan as a whole; and (5) the relative merits of the parties' positions." While there is not much evidence suggesting that United Staffing acted in bad faith, the remaining factors announced by the Tenth Circuit are supported by substantial evidence. First, there has been no evidence presented by United Staffing that suggests that it is not in the position to satisfy an award of attorney's fees. Second, the court believes that by ordering United Staffing to pay the fees, it will in the future be deterred from failing to review its claim administrators' decisions or at least will properly delegate fiduciary responsibilities to those administrators.

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[63] 29 U.S.C. § 1132(g)(1).

Third, such a deterrent effect will undoubtedly result in a benefit to the plan members as a whole; each claim will now be reviewed by a fiduciary, and plan participants will be on notice of how out-of-network charges will be paid. And lastly, the relative merits of the parties' position were determined in favor of the Geddes. Therefore, having considered the relevant factors, the court awards reasonable attorney's fees to the Geddes.

### *Conclusion*

The court GRANTS summary judgment for the Geddes on their first cause of action[19-1]. As for the Geddes's second and third causes of action, the court GRANTS summary judgment in favor of United Staffing[16-1].

It is therefore ORDERED that the Geddes have proven their first cause of action under ERISA and is therefore entitled to a judgment for payment of benefits denied except for those specifically referred to as "rehabilitative." United Staffing shall pay for Andrew's stay at Primary Children's according to the in-patient benefit rate listed in the Plan. The Geddes are also entitled to an award of attorney's fees under 29 U.S.C. § 1132(g). To enable the court to enter a final judgment, the plaintiff shall have 21 days from the date of this order to submit a form of judgment accompanied by computations of the amounts to be included, with the necessary affidavits and supporting information for determining an award of attorney's fees. United Staffing shall then have 21 days after receipt of the Geddes's submission to file objections.

Dated this 23rd day of March, 2005.

SO ORDERED.

/s/ _____
Judge Paul G. Cassell
United States District Court

## APPENDIX C

**IN THE UNITED STATES DISTRICT COURT**
**DISTRICT OF UTAH, CENTRAL DIVISION**

| | |
|---|---|
| MICHAEL GEDDES and KARI GEDDES, individually and as parents and guardians of ANDREW GEDDES, a minor child,<br><br>Plaintiffs,<br><br>vs.<br><br>UNITED STAFFING ALLIANCE EMPLOYEE MEDICAL PLAN; U.S.A. UNITED STAFFING ALLIANCE, L.L.C., a limited liability company; and EVEREST ADMINISTRATORS, INC., a Utah corporation,<br><br>Defendants. | Case No. 2:03cv00440-PGC<br>**JUDGMENT**<br>Judge Paul G. Cassell<br>(Filed May 4, 2005) |

This action came on for hearing on December 8, 2004 before the Court, Honorable Paul G. Cassell, District Judge, presiding, and the issues having been duly heard and a decision having been duly rendered on March 23, 2005,

IT IS ORDERED AND ADJUDGED that the plaintiffs Michael Geddes and Kari Geddes, individually and as parents and guardians of Andrew Geddes, a minor child, recover of the defendants United Staffing Alliance Employee Medical Plan, U.S.A. United Staffing Alliance, LLC,

and Everest Administrators, Inc., the sum of $134,968.11, with interest thereon at the legal rate until paid.

IT IS FURTHER ORDER [sic] AND ADJUDGED that the plaintiffs Michael Geddes and Kari Geddes, individually and as parents and guardians of Andrew Geddes, a minor child, recover of the defendants United Staffing Alliance Employee Medical Plan, U.S.A. United Staffing Alliance, LLC, and Everest Administrators, Inc., attorneys fees in the amount of $45,539.50, and their costs of action.

DATED this 4th day of May, 2005.

/s/ Paul Cassell
~~Clerk of Court~~
U.S. District Judge

## APPENDIX D

## UNITED STATES COURT OF APPEALS

## FOR THE TENTH CIRCUIT

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| | |
|---|---|
| MICHAEL GEDDES and KARI GEDDES, individually and as parents and guardians of ANDREW GEDDES, a minor child,<br><br>Plaintiffs-Appellees,<br><br>v.<br><br>UNITED STAFFING ALLIANCE EMPLOYEE MEDICAL PLAN; U.S.A. UNITED STAFFING ALLIANCE, L.L.C., a limited liability company, and EVEREST ADMINISTRATORS, INC., a Utah corporation,<br><br>Defendants-Appellants. | No. 05-4142<br>(D.C. No. 2:03-CV-440-PGC) |

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ORDER

Filed February 1, 2007

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Before **TACHA**, Chief Judge, **KELLY, HENRY, BRISCOE, LUCERO, MURPHY, HARTZ, O'BRIEN, MCCONNELL, TYMKOVICH, GORSUCH** and **HOLMES**, Circuit Judges.

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The appellees' petition for rehearing is denied by the panel that rendered the decision. Judge Holloway, a member of the original panel, voted to grant panel rehearing.

The en banc rehearing request was transmitted to all of the judges of the court who are in regular active service. A poll was requested, and a majority of the active judges voted to deny rehearing en banc. Judge Briscoe voted to grant en banc rehearing.

Entered for the Court

/s/ Elisabeth A. Shumaker
ELISABETH A. SHUMAKER
Clerk of Court